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Nursing Medical Patients

An Analysis of Problems Encountered by Student Nurses in Caring for Them

FLORENCE K. WILSON, R.N.

ABOUT four years ago it occurred to me that, although from the questions asked by the students nursing patients on the medical wards, I had a vague idea of the problems which they were encountering, I had no tangible record of those problems. I thought if I had such a record I might know better what student nurses needed in a course in medical nursing. To get a record of the problems in nursing various medical diseases I inserted the following question in the case report outline: What difficulties did you encounter in nursing this patient? As there were only a few reports coming in each year they have been saved, and this year an advanced student in medical nursing tabulated the problems.

The reports were first divided, according to diagnosis, into studies in circulatory diseases; in respiratory diseases; in diabetes; in Basedow's disease; in gastrointestinal disease; and in nervous diseases. The problems were taken from the reports and under each disease they were classified into nursing problems and personality problems. Both of these classifications are more or less arbitrary. If the patient had more than one disease, the report was classified under the disease being treated. The classification into nursing and personality problems was even more difficult as personality lies at the bottom of so many nursing problems. There may be a wide difference of opinion as to where certain problems are to be placed. For instance, language difficulty has been included as a nursing problem in cases where sign language is inadequate in giving necessary instructions to the patient, but in reality the problem of dealing with a person who does not speak English, is a personality problem.

These problems represent only those of bedside care for the patient, and do not include any problems due to inadequate supplies on the ward, inconveniences of nursing in an old hospital, or any problems of ward management. All the reports have been made by young student nurses doing bedside care of medical patients. They probably do not include all of the problems of bedside nursing, as the number of cases is small and it may be that the nurse has not recognized all the problems she encountered. The cases are

more or less selected cases as usually the student made her report on the patient most interesting to her.

The results obtained from this study will be presented in a series of articles in the *Journal*. The first articles will give the problems classified under the diseases. The final article will give the problems with no reference to the disease under which it occurred. It is hoped that with this very definite statement of problems a corresponding statement of solutions may be collected.

The first problems to be presented are those found in nursing cardiacs. Table No. 1 gives the frequency for each type of problem found on cardiac studies. As the necessarily short statements given in the table lack the vitality of the statements made by the student nurses, several of their statements follow the table. Two of the best case reports have been included to show how the knowledge of social and medical facts have helped the student to recognize and solve nursing problems. The case report outline has been appended to show what help the student had in organizing her material.

Table No. 1—Problems With Cardiacs

PROBLEMS STATED ON 105 CASE REPORTS WRITTEN BY STUDENT NURSES

Difficulties in giving nursing care		73
To persuade a patient to eat	15	
To urge medication	10	
To make patient comfortable	10	
To induce personal cleanliness	8	
To prevent decubitus	7	
To keep accurate intake and output	7	
To limit fluid intake	4	
To give required attention in specified time	4	
To overcome objection to treatment	4	
To keep bed and stand in order	2	
To get patient up in chair	1	
To explain use of rectal thermometer	1	
Difficulties with personality		64
To overcome irritability	9	
To discourage introspection	8	
To develop good mental attitude	8	
To remove home worries	8	
To obtain coöperation	7	
To keep patient occupied	6	
To gain confidence of patient	5	
To build hope in patient	4	
To overcome self-consciousness of patient	3	
To remove language difficulty	2	
To limit discussions	2	
To prevent familiarity	1	
To give patient same nurse	1	
Difficulties in giving rest		31
To keep in bed	18	
To keep quiet in bed	12	
To avoid too much talking	1	

SOME OF THE STUDENTS' STATEMENTS OF PROBLEMS

1. One problem was to keep her back free from sores. She was washed and rubbed daily with alcohol. After she refused to use a rubber ring, I propped her on her side with pillows and raised the foot of the bed, but even then her back was reddened and rather sore.

Another problem was to keep her from drinking too much water. Sometimes explaining to her just why she should not have it and keeping it from her sight were sufficient. At other times I had to resort to chipped ice and moistening her lips frequently.

The problem of keeping her warm and dry was more easily solved, it was simply necessary to change her bed and gown frequently.

Another problem was that of quieting her when she became hysterical. Sometimes sympathy helped, occasionally I could appeal to her sense of fairness, sometimes reasoning or force helped, but very frequently I could do nothing with her.

The problem of giving her digitalis was solved by giving it in a rectal tap. However, the problem of giving her caffeine citrate remained the same. Sometimes she would retain it, but more frequently it was vomited.

Rather a difficult problem was that of keeping her mouth clean. She was given mouth care at 8, 12 and 4. She could do that very nicely for herself, if she would; but sometimes I had to do it, using her brush and swabs.

The fact that she was so badly decompensated presented a problem, as it took so much time to feed and give her morning care. I had to plan my other work so as to give as much time as I needed for her.

2. At first the patient was so drowsy, it was necessary to feed her and also to rouse her constantly during the process. She also needed encouragement at other times to eat.

3. I had a hard time keeping her in bed. I think she did get up sometimes at night. Sometimes she had no appetite and it was hard to get her to eat.

4. She was put on a low protein, salt-free diet. This was very hard for her to bear. She kept asking for chicken legs and salt and could not understand why they were denied.

5. A number of times he became toxic on his digitalis and it had to be administered by rectum.

6. The patient's weight and inability to move easily constituted a real problem. The upright position in bed which she must maintain made the problem more difficult.

7. It is always difficult to make a cardiac's bed comfortable if he must be kept propped up in bed. This patient would slide down in bed, getting his back at an awful angle.

8. During the first few days after admission, the least movement caused great distress to the patient. As the patient always slept on her side, in doing morning care I usually washed her back first and made one side of the bed while the patient was still on her side.

9. Making the patient comfortable. She perspired profusely and so had trouble with her back and hips. She required special care to her back for most of the time she was in bed.

10. When this patient first came into the hospital, he did not like to brush his teeth and he also complained of the *liquor antisepticus* making his mouth sore. Upon explaining to him that it was just as bad to let your teeth go as not to take a bath, he said he would try brushing them. Now I do not have any trouble with him and his gums do not bleed, as they did at first.

11. Being such a large heavy person, her back started to break down, and it was such a satisfaction to work with her and see the redness and small pimples disappear.

12. Collecting urine specimens at the proper time and making sure they are saved.

Keeping the patient in bed when he began to feel well.

Keeping the patient from smoking in bed.

Keeping accurate account of intake and output.

13. The first problem was my own lack of interest in the patient which vanished upon better acquaintance with her and her family. The second problem was lack of appetite. This was solved by giving her a wider choice of foods.

14. She demanded more than her share of attention.

She gave her state of health a little too much attention of the wrong kind.

Report No. 1—Study of a Decompensated Cardiac

THIS patient, Mary Doe, was admitted to Lakeside Hospital through the accident ward on 6–25–28. She is 38 years old and keeps a home for herself, her husband, and one daughter, Alice, aged 13 years, of whom the mother is very proud. She is pretty, a companion to her mother and especially fond of her, as well as of much help to her. They are a very devoted little family. Alice went home from school to her father, helped him prepare their dinner, and cleaned up the house. Sometimes she came to the hospital with her father to see her mother; always over the week-end when she did not have lessons to study. She stayed nights with a neighbor who was a friend, and Mrs. Doe never worried about her until just before she went home, when she began to feel that Alice and her father were not doing enough cooking. Mr. Doe worked nights, and came to see his wife almost every noon as well as every evening before he went to work. Mrs. Doe felt she was a very fortunate woman to have such a wonderful husband.

Mrs. Doe was an intelligent woman. She was always concerned about the welfare of the other patients, but not personally interested in them. Anything unusual which happened on the ward disturbed her especially and seemed to cause her condition to be worse. She was interested in all the nurses and became personally acquainted with us all. Sometimes I thought she was making a special study of us. She liked to know what we did while we were off duty. That same thing seems to interest many

patients; they seem to expect us to do very unusual things while we are off the floor.

Mrs. Doe has never visited any dispensary. She was sent into some other hospital at one time for treatment of her heart condition, but she has always employed a private physician.

She had average health until the onset of the present disease. She had the usual childhood diseases, including scarlet fever. Her attack of scarlet fever was at the age of 12 years, after which she was not able to take much exercise without shortness of breath. She has had painful hemorrhoids since the birth of Alice, thirteen years ago, a yellowish foul discharge for the past three years, and dysmenorrhea for the past year.

Seven years ago she had rheumatic fever and has had almost constant trouble since that time, with pleurisy every winter and occasional joint and shooting pains. Her palpitation of the heart dates back to seven years ago, as well as her edema of feet and legs.

Her condition became worse on Tuesday and she called in Doctor Wise; he in turn sent her into the hospital on Saturday. Her condition was quite acute upon her entry. She was *cyanotic*, her *blood pressure was unobtainable*, her *hands and feet cold*, her *pulse very weak and small*, an *apex rate of 140* and *a radial rate of 88*, the *superficial jugular distended and tortuous* and *edema of the feet and legs*. Her diagnosis was mitral stenosis, cardiac decompensation and auricular fibrillation.

The laboratory findings were:

Urine cloudy, a few hyaline and granular casts and albumin 2 plus upon admission, and on the 31st, many casts and albumin 3 plus as well as a few W. B. C's. On 10–22 the urine was negative except for epithelial cells. On 9–14 a P. S. P. test was done with only 15 per cent coming through the first hour and the same amount the second hour. This totaled only 30 per cent in two hours, which is low. A Mosenthal was done the following day, which was practically normal. The P. S. P. was repeated on 10–22 with only a 5 per cent increase at the end of the first hour. Her white blood count was 25,300 upon admission and remained high until after her temperature became normal. This temperature which ranged between 37 and 38–5 with the high W. B. C. was thought to be due to an infarct at the base of the left lung. She had a marked tenderness there and many râles; these disappeared with the temperature and the W. B. C. slowly came down.

Physical findings:

"The heart was moderately enlarged extending two fingers' breadth to the right of the sternum and three fingers past the axillary line. There was a systolic thrill, a systolic impulse and a diastolic impact over the right ventricle. There was marked fibrillation giving a pulse deficit ranging from 0 to 30. Her *edema* remained until a few days before her discharge. She was short of breath when she was discharged."

Objective symptoms which I associate with the disease:

High color in cheeks.
Cyanosis.
Edema of feet and legs.
Scant, concentrated urine.
Slight cough.

(Mrs. Doe was not able to cough effectively when she entered the hospital. Examination showed a complete paralysis of the left vocal cord. This condition gradually subsided.)

Shortness of breath.
Pulse irregular.
Pulse deficit.
Extremities cold.

Subjective symptoms:

Some pain over heart.
Nervousness also objective.
Generally uncomfortable.

Her nursing care consisted of general nursing care for a patient on cardiac routine, plus hot dressings to the rectum. This last treatment was to relieve painful hemorrhoids and a rectal abscess.

Medications:

Digitalis, dosage from 2cc. b. i. d. to a tablet, grs. ¾ b. i. d.
Caffeine citrate, dosage gr. 3 and 5—total of 79 grs.
Theobromine, dosage grs. 15—total of 30 grs. (The digitalis was the most effective, but the result of the three together was very good.)
Mineral oil was given as an intestinal lubricant.
Belladonna and opium suppository—to relieve hemorrhoids.
Sedatives for sleeplessness.

A nurse assisted the doctor in doing a blood chemistry.

Nursing problems:

Mrs. Doe was a pleasant and most coöperative woman, still she presented a few nursing problems. The first of these was to make her comfortable in a cardiac bed. She did not like the abruptness of the bend in the mattress. I overcame this by raising the back only a little and putting in several pillows—five. The rubber sheet in its usual place made many wrinkles at her back. By putting the lower edge of the sheet even with the foot of the bed, there was no bend in the sheet and so no wrinkles, still the sheet served its purpose.

The second problem concerned her food. She never ate much of anything, although she never complained. White bread was one thing she would not eat, the one thing she was usually given. If she was not feeling well enough to eat what food was on her tray, some one usually fixed her a hot drink and white bread toast. The whole wheat bread seemed to be a prize, there so seldom was any, especially in the morning. With the assistance of the kitchen maid one is able to accomplish anything in the kitchen. She saw that Mrs. Doe had her whole wheat bread.

Her accurate output was a third problem. She would seldom ask for two bedpans, and the doctor on the ward insisted that a certain amount, plus, did not mean a thing.

The hot dressings to the rectum was the fourth problem. How to keep the bed from getting wet? A rubber ring with a pad under it solved this.

I enjoyed just about every minute spent in nursing this patient. She was interesting as a patient, as a mother, as a satisfied wife, and as a well adjusted human being. She has been in bed the greater part of each winter for the past seven years, yet she did not complain, she considered herself a fortunate woman. She had her husband and Alice besides.

I do not by any means understand all about cardiacs, but I have already asked all the questions that I am able to ask.

Mrs. Doe's recovery was good. The decompensation symptoms disappeared, the heart rate slowed down and the pleurisy cleared up. She still had a persistent fibrillation. Quinidine was not given because the doctors suspected small emboli. In spite of this, she cannot look forward to an uneventful future; as far as her heart is concerned, she will probably have recurrences of the same symptoms that she has had for the past seven years.

She was discharged on 11–3–28 with advice to remain in bed except for brief intervals; to return to the dispensary in two months. Her medication at home is a 3–4 gr. digitalis tablet b. i. d.

They lived on one floor, upstairs, so there were no stairs to climb except to go outside, and Mrs. Doe will not go out much. They plan to move downstairs before spring, but I wonder if they will. They have lived in these same rooms ever since they moved to town four years ago, and she has known during all that time that she had heart trouble. A young relative

has come to do the work and care for Mrs. Doe at home.

The references are listed with my reading for this course.

Report No. 2—Potential Cardiac

JAMES CARTER is a young boy, seventeen years of age, who before his entrance into the hospital, May 16, 1928, was employed by a Cleveland manufacturing company as a laborer doing odd jobs, all of which were entirely too heavy for a boy of his age. There was no one directly dependent upon him for support, but his father demanded that he give him his entire fifteen-dollar weekly salary, not even being allowed to keep for himself money for one show a week.

James is very coöperative, and will do just as he is requested when asked kindly. It is evident that he is used to a life of quarreling, and a little gentleness and a few kind words go a long way.

His father came to this country in 1900, and settled in Pennsylvania. There, in 1906, he married a woman who is very nervous, and has a very disagreeable disposition, is a very poor housekeeper, and as a result keeps an exceedingly dirty home. Mr. Carter is a steady worker, and when he and his wife moved to Cleveland, in 1907, he was employed by the Bisselli Company, where he has worked intermittently since then.

The family had its first connection with the Associated Charities in 1913.

At Christmas time, 1914, the father and mother had a quarrel which necessitated the calling of the police. The man, attempting to hit the policeman, was shot. However, he in time recovered and resumed his duties at the Bisselli Company.

In 1921 the family bought a home, but their standards of living continued to be very low. The man was reported to be exceedingly cruel to the woman. Nevertheless, he was progressive enough to take out his citizen's papers at this time.

In 1922 the mother desired to obtain a divorce, but by the persuasion of the faculty members of the school which the children attended, she, for their sake, did not get this.

In September of the following year they bought a farm of eighty-five acres, and moved to the country. They only remained one month, returning then to Cleveland, as the neighbors would not tolerate them.

From this time, until 1927, the family had no connection whatsoever with any organization in the city. But in April of that year the father visited the Charity Association, and complained that the mother and Jennie, the eldest daughter, were taking part in illicit relationships with other men. Two weeks later, the woman complained at the same office of the man's swearing, and also that he kicked the children.

One day the following month, Mrs. Carter appeared at the Associated Charities completely inebriated. During the same month, Miss Howard of the Juvenile Court inquired of the Associated Charities as to what they knew about the treatment of the children, and as a result Mrs. Carter was sent to Marysville, was paroled, but was returned on a similar charge. She has just been released during the past two weeks.

After the court hearing which sent the mother to Marysville, physical examinations and I. Q. tests were given all the children. Jennie was found to be pregnant. The baby, however, died at birth. All the children were found to be somewhat subnormal, with the exception of one little girl whose I. Q. test was ninety-four, James' being sixty-five. Juvenile

court wanted to place him in an institution in Columbus, but the father would not hear of this.

At the present time, the three oldest girls are under the care of the Women's Protective Association. Bessie, who is nineteen, married about one month ago, and has a young baby. Her husband is not working, resulting in their living at her home. The two youngest girls are in St. Joseph's Home, and the three little boys are in Parmadale.

The family had no connection with the Lakeside Dispensary before this time. At one time, two of the younger girls had chorea, and were in Rainbow Hospital quite a long time. One little girl is, at the present time, receiving ultra-violet-ray treatment.

James was in the hospital six days before I started to care for him. His illness had started suddenly about two days before, when he drank a glass of corn whisky, which he says is the first he ever drank and, incidentally, will be the last. He entered the hospital through the dispensary.

Laboratory findings:

Wasserman—negative.
Lumbar puncture—negative.
Pressure—normal, clear.
Cells—three.
Globulin—Pondy Tr.
Albumin—Ross Jones Fr. Tr.
Benedict reduction—Fr. Tr.
Lange collodial gold test—negative.
M. P. T.—negative.
Urine—amber, 1,032.
H. b. (Sahli)—65%.
White blood count—9000.

"Patient is a well developed, white, seventeen-year-old boy, exhibiting vigorous purposeless athetoid movements but only occasionally facial grimaces. Speech O. K., except with convulsive movements.

Skin—Marked tendency to furunculosis. Skin on back and buttock chapped but skin intact. Nose chapped.

Lungs—Lungs resonant throughout, no râles.

Heart—No definite cardiac murmurs. No cardiac enlargement.

Pulse—Rhythmic, regular, good volume, and tension.

Extremities—Good muscle tone.

Neuromuscular—Biceps patella Achilles all moderately hyperactive. Abdominals equal normally active.

DR. DAVIS.

Symptoms:

From patient:
Headache—always following, and probably due to ultra-violet-ray treatment.
Light hurts eyes.
Cramps in legs.
Head cold.
Peculiar lump felt in throat.
Felt hard lumps in abdomen.
Bump on back of head, due to hitting his head when moving.

Observed by nurse:
Aimless movements.
Red rash over entire body, due to luminol.
Light hurts eyes.
Skin eruptions on face.
Small infection on finger.
Unable to wash.
Unable to feed self.
Pulse regular, rhythmic, of good volume.
Nose bleeds (slight).

When beginning to care for James, his back was covered with eruptions. I washed it thoroughly three times a day, and applied cold cream and powder. Also, instead of using sheets on the bed, which seemed to rub so terribly, I used bath blankets. A rubber drawsheet seemed to be irritating to him, and was always wrinkled, thus helping to keep his back inflamed. Consequently, it was removed. As a result, when going home after being in bed six weeks, his back was clear and in good condition. Also, his elbows when reddened, I treated with cold cream and powder.

His headaches after the ultra-violet-ray treatments were greatly relieved by ice compresses.

Around his nose there were eruptions to which were applied ammoniated mercury, and these cleared up entirely.

On the small finger, James developed an infection, for which hot soaks

were applied t. i. d. This healed very nicely.

During the first few weeks of his hospital stay, James' movements were so aimless that there was danger of his hitting his head. A pillow was stood at the back of the bed, and tied, and this served its purpose wonderfully well.

Both in order to help keep James quiet, and because it was impossible for him to do it, I fed him entirely throughout most of his hospital stay. He was unable to bathe himself, and was urged not to do anything at all.

His appetite was enormous, and even though he received a high caloric house tray, he was never satisfied, and so, each day, I tried to fix him something extra that would be both appetizing and nutritious. He also always drank two glasses of milk with his meals.

James received luminol and elixir triple bromides for a long period of time, and these seemed to help quiet him greatly. These were, however, discontinued when he developed a red rash. He frequently received chloral hydrate at night, and I usually found him sleeping soundly in the morning. Occasionally he received milder sedatives, such as luminol, after it had been discontinued as a regular medication. He also received Fowler's solution for a period of two days. Magnesium sulphate was given as a cathartic, after which he usually said he felt better. Several doses of I. Q. S. were given, and acted as a general tonic.

Treatments and tests assisted in:

Removal of core from infection on small finger.
Lumbar puncture.

The progress of this case has been unusually interesting to follow, because it could be noted from day to day. When I first started to care for James, he could not remain in one spot for any length of time. He had no control of either arm, and very little of his legs. The fingers on the right hand assumed one position and stayed that way. The left was little better. It took the assistance of the orderly to take his temperature, and also to hold him on one side of the bed while I dressed the other. He could neither wash nor feed himself, and what he said could not generally be understood. As time went on, it gradually became possible for him to move his legs as he desired. His left hand improved so much, that he could hold a piece of bread in it. After I had cared for him about three weeks, it became possible for him to lie fairly quiet while I made the bed, without any assistance. He could take his thermometer himself, and talked much plainer. Towards the last of his stay, he could wash his own face, and when he went home, he could feed himself entirely, if some one cut his food. He talked coherently, and was able to stand up, and even walk very well.

Perhaps *the* problem in this case of chorea, with which everything else was connected, was keeping him quiet. One factor which seemed to help most, was keeping him in a room by himself, with very few people coming in to see him. He was not allowed to read, but was urged to sleep as much as possible. A darkened room seemed to help this greatly. He was disturbed as infrequently as possible, everything being done for him at one time. His aimless movements used up an abundance of energy, so he was given all the food he could possibly take. Towards the end of his stay he insisted on getting out of bed. This was solved by taking away his gown and slippers, and by an order for a restraining sheet for one hour if he

ventured out of bed again. (He never needed this.)

The thing that made this case most enjoyable was the progress that could be noted from day to day. James was very coöperative, and because of his home conditions was very appreciative of all one did for him. Being a boy who had had no advantages, there were many things he was interested in but knew nothing about. He asked many questions, and it was really "fun" to try to explain them in English he could understand.

The greatest question in my mind, is just what kind of a condition this boy will be in one year from now. He improved rapidly while in the hospital, but, returning to a home of his sort, just what will happen when he does not have the abundance of proper food, or proper rest, or someone to help him do the many things that are so hard for him to do? Also, just what condition his heart will be in. What caused his case of chorea? Is it a disease for which there is hope of finding a specific? Is it contagious? Some additional good references for reading.

A case of this sort should look forward to a future of rest and quiet, with a gradual return to the daily activities of life. He has to be very careful, or he will develop a cardiac condition which will either shorten his life, or cause it to be a very painful one, and also a very inactive one.

James was instructed, and also his mother, by the doctor, that he should go home and go to bed. After several days of rest he might be up some, out in the sunlight, as this would help him more than any one thing. He was told he could eat any food, except those highly seasoned. He should drink lots of milk, and should not lead an over active-life. He was not told to return to the dispensary for observation. As his nurse, I stressed the point of plenty of rest and good nourishing food.

James left the hospital quite suddenly, and there were no plans made for his future. It had been a question in the mind of the social worker, whether or not he should be allowed to go back to the home from which he came. Sending him to some sort of camp seemed to be the best possible solution. However, the case is directly under the control of the Children's Bureau.

References:

"Text Book of Medicine," Blumgarten.
"Principles and Practice of Medicine," Osler.
"Encyclopaedia Brittanica."

Case Study Outline
Medicine

Patient's name.
Date of admission.
Diagnosis.

I. Knowledge from related fields helpful to the nurse.
  1. Social history.
    a. Age.
    b. Occupation.
    c. Number dependents.
    d. Points in personality which you can use in gaining coöperation.
  2. Medical History.
    a. Dispensary or other past history.
    b. Present illness (up to the time you start taking care of the patient).
    c. Laboratory findings, their significance.
    d. Physical findings, relative to this disease.

II. Problems of Nursing Care.
  1. Symptoms.
    a. The symptoms should include:
      (1) Any change in cardinal symptoms such as increase in rate, or change in the quality of the pulse or respiration.
      (2) Any abnormal condition which you observe, such as eruption on the skin, jaundice, or cyanosis.
      (3) Any abnormal condition of which the patient tells you, such as pain located in the pit of the stomach.

b. Underline those symptoms which you associate with the diagnosis.

2. Nursing treatments, results.
3. Medication, results.
4. Treatments and tests by the doctor with which the nurse assists.
5. Progress.
6. What difficulties were encountered in nursing this patient? Give any attempted solution.
7. What did you enjoy about nursing this patient?
8. What questions have you on this case?

III. Plans for this patient.
1. What medical future does this patient look forward to?
2. What instruction was the patient given on his discharge for his care at home?
3. What are the social adjustments and plans for the patient?

IV. References read on this disease.

The Bacterial Significance of the Handshake

LEILA I. GIVEN, R.N., B.S.

THE custom of shaking hands is a very old one and, like most other customs of mankind, has passed through many stages of development. It probably had its origin among primitive peoples, where the hand was symbolic of strength and power. To extend the hand to a stranger with the palm displayed was to assure him that there was no weapon concealed.

In the early religions, the hand was also a symbol of power. Among the early Greeks, the gods were worshipped with upraised hands. At another time, throughout Europe, the presentation of hands joined palm to palm was required from an inferior when acknowledging obedience to his superior. During feudal times, the vassal would place his joined hands between those of his master.

It was a custom of the early Greeks to extend the right hand of fellowship to the stranger who entered their gates. Salt was also presented to him as a symbol of hospitality and an assurance that no harm would come to him while sojourning there.

Today there are many modifications of the handshake. The Chinese shake their own hands when meeting friends; the Ainus, a race of people on the Island of Saghalien, and the southern Kuriles, have a custom of rubbing their palms together and stroking the beard; in the Bank Islands, a man locks the middle finger of his right hand with that of the person he meets and pulls it away with a crack.

During the last generation we have experienced the customs of finger-tipping and the high hand-shaking. These, however, have given way to the present custom of taking the hand in a firm, cordial clasp.

At the close of a recent meeting of a well-known organization, a member was heard to exclaim, "What an inspiring meeting! I'm sure everyone will carry *something* away from it."

My inward response to the above comment was, "I'm sure that everyone *will*," but my thoughts, at the time, were *not* of the meeting. With the words, "Everyone will carry *something* away," there came to mind a certain effusive young woman with an acute head cold who had, undoubtedly, felt it a moral obligation to attend that meeting, and whose greatest activity, both during and following the meeting, appeared to be concentrated in her right hand which served, in the first instance, as a cover for her nose and mouth when unable to suppress a cough or sneeze,

and in the second, as a means of greeting her friends and acquaintances.

At this point I tried to recall the number of people with whom this person had shaken hands, and others with whom they had exchanged greetings. Figures began to loom large, and then it was that my mind began to concern itself with some such mathematical problem as the following:

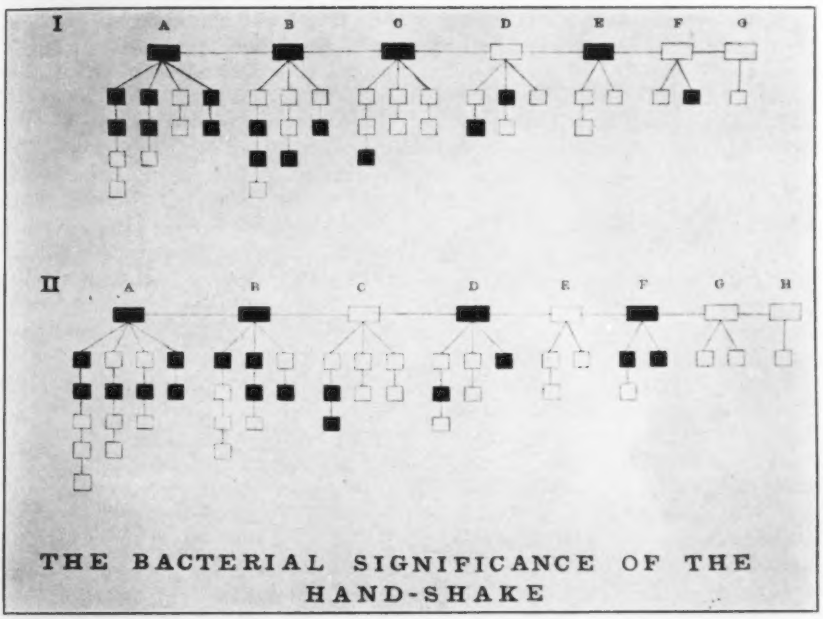
> If a young woman, whose hands are known to harbor millions of infectious bacteria, shakes hands with five people, and these, in turn, shake the hands of five others, and each of these the hands of three others, and so on, *ad infinitum*, on the hands of how many people will the original bacteria be found?

Recognizing the fact that all problems require some sort of solution, a few days later a similar problem was presented to the students of a class in bacteriology who were asked if they would be interested in helping to solve it. Like all Freshmen, they were most enthusiastic.

The experiment was carried out in two classes, designated I and II. The students in Class I were divided into seven groups, A, B, C, D, E, F, and G, each with a varying number of students. (See upper diagram.)

In preparing for the experiment, the hands of each student were scrubbed for five minutes, soaked in a 1-2000 solution of bichloride of mercury for three minutes, rinsed and dried.

In the palm of the right hand of the first student in Group A was placed a loopful of a twenty-four hour broth culture of Bacillus Prodigiosus. (The loop used measured 6 mm. in diameter.) This student then shook hands with the first student in Group B, after which she shook hands with four students in her own group. These, in turn, shook the hands of four



THE BACTERIAL SIGNIFICANCE OF THE HAND-SHAKE

others in Group A, and two of these with two others, and so on.

The first student in Group B now shook hands with the first student in Group C, after which she shook the hands of three members of her group. The procedure was continued until the members of all the groups had shaken hands as indicated in the upper diagram. When the hand-shakings had been completed, cultures were made from the hands of all the participants.

The results of the experiment as carried out in this class are shown in the upper diagram, the black squares and oblongs indicating the hands of those students from which positive cultures were obtained.

The students of the second class were divided into eight groups, A, B, C, D, E, F, G, and H, each with a varying number as in Class I.

Considering the possibility that a sufficient amount of bichloride of mercury might have been retained on the hands of some students in the first class which might have inhibited bacterial growth, it was decided to omit the chemical in this class. In other respects the experiment was carried out in the same manner as in the first class, the results of which are shown in the lower diagram.

While the results in both cases do not, perhaps, give an exact answer to the original problem, they, nevertheless, are convincing. Had more students been available, or had a different grouping been made, the possibilities might have been considerably greater. However, with the results as they stand, the experiment has, in part, fulfilled its purpose, namely to prove to the students that the hands are agents of bacterial transfer, and to impress them with the need of exercising the utmost precaution at all times in order to safeguard others as well as themselves.

One may well ask why sanitary America persists in a custom which has nothing to justify it from the sanitary standpoint, but national customs are not easily abolished. That hand-shaking will ever disappear from our midst may be doubted, and our only hope lies in the education of people to a realization of the danger of hand-transmitted infections, and to the use of those preventive measures which lie within the realm of personal hygiene.

It might be said, in passing, that the Chinese custom of shaking one's own hands when meeting friends, is a most commendable one, and one we might substitute for our less hygienic one—at least our bacteria would then stay at home.

A Battle Against Maternal Mortality

DURING the five years ending with 1927, the Victorian Bush Nursing Association of the State of Victoria, Australia, attended 2,273 confinements of white mothers without the loss of a single mother. This organization was started in 1910 for work in the rural districts of the state, and its efforts have been so successful that in 1927, the sparsely settled "bush" had the lowest maternal mortality rate in Victoria, while the city of Melbourne, which contains more than half the population of the state, had the highest. The average rate for the state was 5.58 per 1,000 live births, which contrasts favorably with the rate during the same year, 6.47, for the birth-registration area of the United States.

This successful record is attributed to the adequate training of both doctors and nurses and their excellent coöperation, insistence on continuous ante-natal supervision, and properly planned, staffed, and equipped hospitals to which all complicated cases were removed at the earliest moment.—Children's Bureau, U. S. Dept. of Labor.

An Educational Exhibit

Shriners' Hospitals for Crippled Children[1]

FLORENCE J. POTTS, R.N.

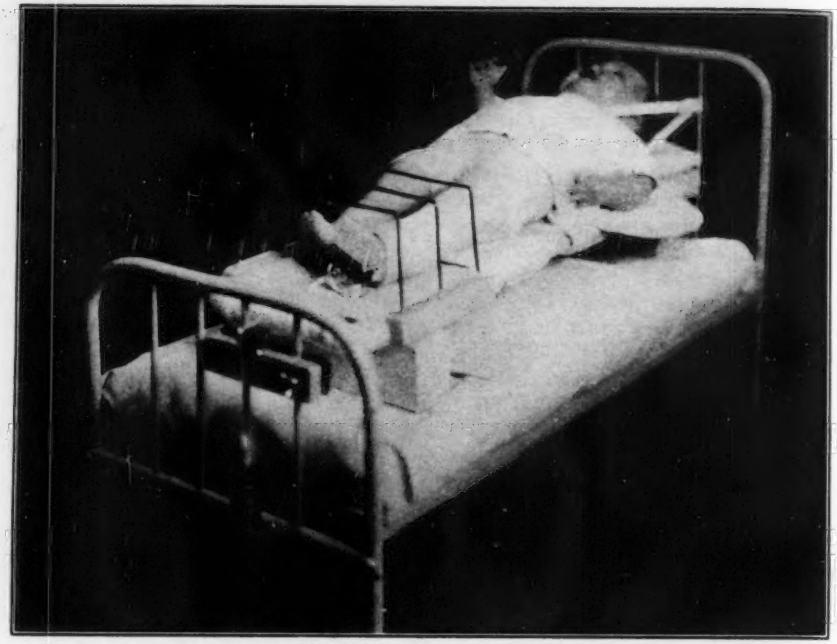
THE Shriners' Hospitals for Crippled Children displayed their first educational exhibit at the American Hospital Association's thirtieth annual meeting, in August, 1928, at San Francisco, Calif.

This, their first attempt to bring to such perfection will be striven for in future efforts. This exhibit was merely a nucleus to which it is hoped something more of educational worth can be added as time advances. It is the aim of the Shriners' Hospitals to serve effectively and to bring before the hospital world a constructive, practical contribution, like all things which are born of ideals, was not perfect in uniformity of detail, but hospital people from time to time the great work which is being carried out for crippled children in these fifteen orthopaedic hospitals, with over seven hundred daily occupied beds, scattered throughout the United States and Canada.

SHRINERS' HOSPITALS FOR CRIPPLED CHILDREN BOOTHS AT THE AMERICAN HOSPITAL ASSOCIATION, AUGUST, 1928

The Shriners' Hospitals for Crippled

[1] A part, only, of the interesting appliances included in the exhibit are shown here. Other equipment will be shown in later issues of the *Journal*.



BED CRADLE AND ARM REST

Children have a unique opportunity to do a definite piece of original work, and exhibits seem to be an ideal way to present to hospital workers the results of what is being worked out mechanically by our specialists to facilitate the treatment of patients in the orthopaedic group.

The average nurse who has been trained in a general hospital, if perfectly frank, will admit that the training, if any, she received along orthopaedic lines, during her three years of training, was woefully limited. There was always a confusion of ideas when the specialist was about to apply a traction or asked for any appliance with which to adjust or improvise certain treatment of an orthopaedic nature. It usually meant an embarrassing moment while she scanned cupboards or ran hurriedly from floor to floor to find the required articles. She was never just sure, even after instructions had been left, whether or not the pulley was pulling at just the right angle; and the surgeon himself must have had misgivings when he left her with this responsibility.

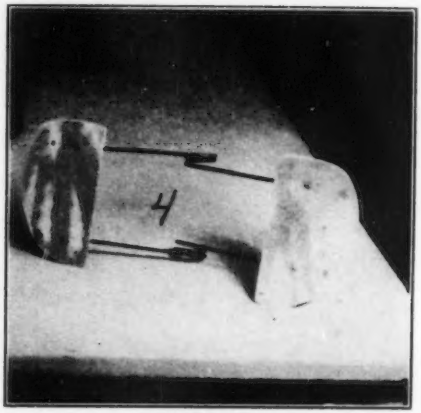
Complicated apparatus, in some cases, may be justifiable even to the extent of requiring an expert mechanic to adjust it; however, as time goes on, the tendency of most orthopaedic specialists is to eliminate as many screws and bolts as possible and to simplify and use apparatus and equipment which can be easily adjusted and understood by the nurses who must be in attendance twenty-four hours of the day.

The hospitals, then, where only orthopaedic patients are cared for, have a real responsibility to discharge. The opportunity is theirs to create and originate methods and appliances

which can be used by those who have not the time or means to perfect such treatment, and then to pass it on as information for all.

From the increasing number of affiliated schools of nursing and the number of graduate nurses availing themselves of the educational opportunities in this group of special hospitals, it will be observed that a keener appreciation of the need for more intensive training on the part of the student nurse in orthopaedic nursing is realized. The affiliated student is required to make studies of two cases during the two months' course in orthopaedic nursing at the Shriners' Hospitals for Crippled Children. These are selected in order to give her an opportunity of studying the case previous to the operation, and for some days following. During this period she is also required to observe a number of operations.

The student spends one month on each ward of the hospital, and is assigned her case the first day, with an introductory talk from the instructress, on the particular patient, his condition, etc. During the first month, apart from the lectures received from the surgeon, conferences are held with the supervising nurse on the ward, the instructress, and the student. The student is encouraged to approach the instructress, the head nurse, or the interne of the hospital at any time she is facing a problem in regard to her particular case. Later in the period more frequent conferences take place between the instructress and the student, when the case is gone into very thoroughly, and all the available material pertaining to this particular type of disease, or orthopaedic condition, is studied. An endeavor is made to emphasize the social side, as well as the surgical and material history of the case, and an attempt made to teach the student nurse her place in the hospital and community as a teacher of health promotion, and disease prevention.



ARM REST

Case studies have been most effective in arousing the student's interest in the various conditions found in the hospital, and, as her time is limited, concentration on at least one case makes a satisfactory basis for further study of the particular condition.

The following is an outline of instruction in nursing procedures carried out in the Units where affiliated students are on duty:

I. Principles of frames.
   How made, covered and applied.
   Classification of deformities.
II. Pre-operative care for Orthopaedic cases.
   Post-operative care for Orthopaedic cases.
III. Tuberculous spine:
   Symptoms.
   Principles of treatment.
   Method of covering posterior and anterior shells.
IV. Method of bathing tuberculous spine.
   Care of child in posterior and anterior shells.
   Care of child in recumbent position.
V. Tuberculous hip:
   Symptoms.

Principles of treatment.
Method of making adhesive extension.
Method of making stocking extension.

VI. Application of extension to tuberculous hip.
Nursing care of tuberculous hip on traction.
Method of bathing and turning child on traction.

VII. Preparation of plaster bandages.
Application of plaster bandages.
Precautions to be observed in caring for case in plaster.
Method of cutting plaster.

VIII. Rickets—relation to orthopaedics.
Method of caring for child in acute stage so as to prevent deformity.
Bowlegs and knock-knees.
Nursing care before and after operation.
Clubfeet:
Cause.
Treatment.

IX. Anterior poliomyelitis:
Relation to orthopaedic nursing.
Spastic paralysis.
Osteomyelitis.

X. Application of traction to tuberculous knee.
Nursing care of a reduced congenital dislocated hip in plaster and on a high frame.

XI. Torticollis:
Principles of treatment.
Method of making and applying head traction.

XII. Demonstration of orthopaedic apparatus.

Ward clinics:
Tubercular spines.
Tubercular hips.
Infantile paralysis.
Congenital dislocation of hip.
Bowlegs, knock-knees, clubfoot, etc.

The illustrations on pages 258, 259, demonstrate a very practical bed cradle and arm rest, which can be readily attached to a Bradford frame, remaining stationary without ties or fasteners of any kind.

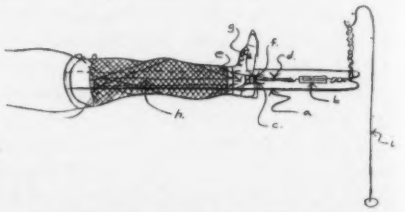
That part of the cradle which holds to the frame is made of wood, hollowed out, allowing it to fit snugly to the tubing.

The top is made of coppered spring wire inserted into holes on the wooden sides. The spring wire permits the cradle being adjusted to frames of various widths. The arm rest is made of spring wire and metal. Illustration No. 3 shows the adjustment before it is attached to the frame.

Traction Apparatus without Weights

THE following is a description, with illustrations, for arrangement of Thomas splint for "intrinsic traction" which has been worked out in one of the Shriners' Hospitals for Crippled Children. The advantage of this traction arrangement which appeals particularly from the nursing standpoint, is its completeness entirely apart from the bed. It is of very simple construction, is easily adjusted, and simplifies the nursing care of the patient. The patient can be readily moved with safety on this frame to the x-ray room or anywhere desired with traction undisturbed.

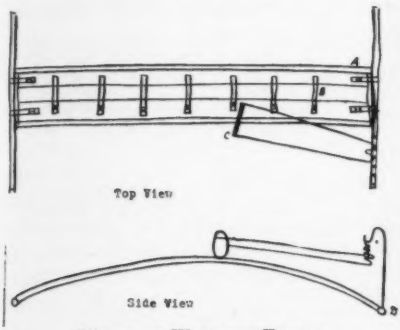
There are no dangling weights or bed-scarring attachments.



ARRANGEMENT OF THOMAS SPLINT FOR "INTRINSIC TRACTION"

a. Extra long Thomas splint.
b. Spring balance to measure amount of traction.
c. Metal "spreader" attached to shoe, with hook on it for rubber bands.
d. One-inch buckles at ends.
e. Smoothly applied adhesive fastened to leg in a long spiral each side having three strips.
g. Shoe to which spreader "c" is fastened just forward of heel.

h. Stockinette holding adhesive close to leg.
i. Upright holding Thomas splint in correct position held in place in holes in lower cross piece of frame.



MODIFIED WHITMAN FRAME

a. Lateral bars, parallel instead of curved, to facilitate making of covers.
b. Buckles and straps holding cover on frame instead of eyelets and lacings.
c. Arrangement of extra long Thomas splint for "intrinsic traction."

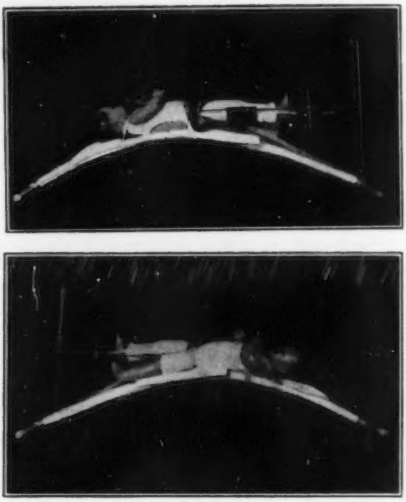
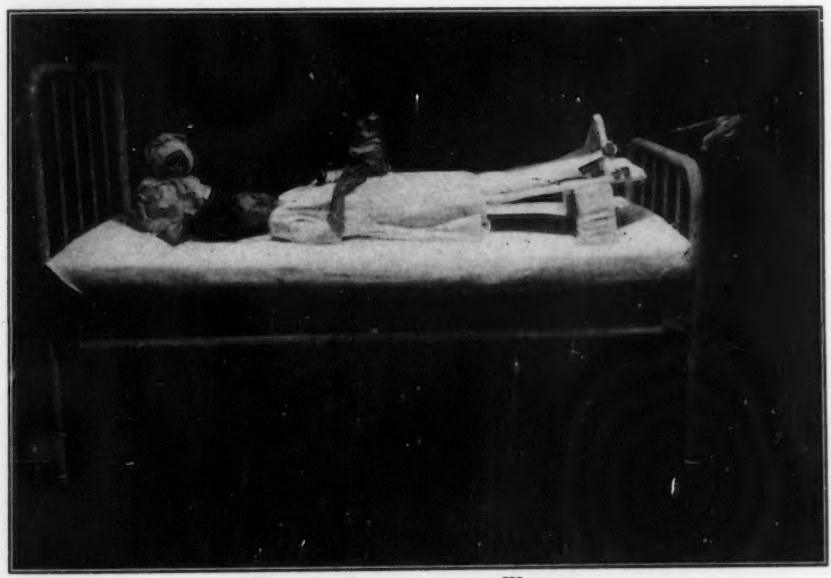


ILLUSTRATION OF INTRINSIC TRACTION APPLIED

d. Upright fitting into holes at lower end of frame for holding Thomas splint.



TRACTION APPARATUS WITH WEIGHTS

Shows the pulley is attached to the bed spring and carries the chain either over or under the bed frame. The chain and weights swing free on the bed and this lessens the marring of paint. The elevation of the frame is shown, the unequal amount at the foot acting as counter traction.

Antidotes for Bichloride of Mercury[1]

W. ZUR-LINDEN

CONSIDERING antidotes for bichloride of mercury, many years ago, various professors of pharmacology, toxicology and some other ologies taught the usefulness of egg albumin. The student was cautioned not to give too much, as an excess of egg white caused the so-called insoluble albuminate of mercury to redissolve. Just what might be considered too much has been determined to be not more than the white of one egg for each four grains ingested; apparently the size of the egg does not seem to matter. If the suicidally-inclined patient knew not, or would not tell, how many tablets or grains of the poison he took, then giving the antidote consisted in making a good guess as to the number of eggs to be used. At any rate, egg albumin forms an antidote of limited value, as the albuminate so formed is still toxic. Chemical antidotes aim at converting the poison into an insoluble compound or making a new or less harmful compound. With this idea in view, I would like to demonstrate the use of lime water as an antidote for bichloride of mercury poisoning. You will observe that a solution of bichloride treated with lime water immediately changes in color. The color is due to the conversion of the soluble bichloride to the insoluble yellow oxide of mercury. The next step should be emetics or gastric lavage and finally demulcents. Sodium thiosulphate has been advocated as an antidote for this poison, but according to Haskell, Henderson and Hamilton,[2] it does not possess any value.

[1] From a paper presented before a Conference of Medical Officers, U. S. Naval Hospital, Portsmouth, Va.

Tests Made in Pharmaceutical Laboratory, Pharmacist's Mates' School, Portsmouth, Virginia

Subject: Qualitative tests for mercury, using Reinsch's test. Fifty grains of bichloride of mercury treated with 550 c.c. (slightly over one pint) of lime water, U. S. P. produced practically a negative reaction with Reinsch's test.

Fifty grains of bichloride of mercury and 50 grains of ammonium chloride in solution treated with a pint of lime water, U. S. P. produced a slightly positive reaction.

Fifty grains of bichloride of mercury treated with the whites of six eggs produced an accelerated positive reaction.

Fifty grains of bichloride of mercury and 50 grains of ammonium chloride treated with egg albumin produced a markedly positive reaction. Curdling was increased by adding a small amount of U. S. P. hydrochloric acid, but the reaction was still strongly positive.

Fifty grains of bichloride of mercury treated with 50 grains of sodium thiosulphate in solution produced a positive reaction.

Fifty grains of bichloride of mercury and 50 grains of ammonium chloride in solution when treated with sodium thiosulphate produced an accelerated positive reaction for mercury.

Conclusion: It appears that slightly in excess of one pint of U. S. P. lime water is a very reliable and efficacious antidote for at least seven tablets of bichloride of mercury, U. S. P. or approximately 52 grains. The U. S. P. allows the use of sodium or ammonium chloride in these tablets; when ammonium chloride is present, sodium thiosulphate appears to be worthless, but lime water is still very effective. In view of the above, it is recommended in cases of bichloride poisoning that gastric lavage with a pint of lime water be used and repeated if thought necessary.

[2] *Journal of the American Medical Association*, Vol. 85, p. 1808.

The Nurse in the Community[1]

ANNE L. HANSEN, R.N.

A Comparison

AT no time, save in war or times of disaster, have nurses been so much in demand as at the present day. From the time when nurses were only secured for the very sick, they have come to be a matter of daily need by persons in every walk of life. During the last twenty-five years the number of nurses required in any community has gradually increased and the schools of nursing have been taxed to provide sufficient graduates to take care of the needs of the general public. It appears, however, that a point has been reached where sufficient nurses are being graduated, and it is even suspected that too many are entering the field of nursing if the numbers of the last few years are to be continued. Furthermore, another difficulty has arisen in that the graduates become more or less segregated and there seems to be a need for some method of distribution. The nursing profession has, in the past, retired before any wave of publicity. From training school days the nurse has been taught to efface self and keep in the background. Today various elements which go to make up modern community life have forced the nursing profession into the limelight and it is faced by a distinct challenge. No one of us would wish the profession to sidestep the issue and therefore time and consideration must be given by nurses everywhere to a careful study of the needs of the profession and its effect on the community.

Present conditions in the nursing world have been brought about in various ways.

First. We are living in a luxurious age and people are demanding unnecessary things and, among others, people of wealth are seeking the trained nurse at times when there is no real need for her services.

Second. People everywhere have been educated to what constitutes good medical and nursing care and are demanding it for themselves and their children. This has been done through the public health groups, through the Red Cross Nursing Service, and by departments of health and education, both in rural and urban communities.

Third. The medical profession relies more definitely than ever before on the assistance of the trained nurse.

Fourth. Municipalities are now providing for nurses, in budgets secured through public funds, as a necessary asset to any health program, whilst private associations provide more nurses to supplement the work of public agencies.

In a word, the trained nurse today is demanded as a daily need by rich and poor and by those of moderate means, where fifty years ago she was accounted as a luxury for the very rich. This has not all happened at once. It has developed rather slowly, but surely, and has resulted in a condition of affairs never dreamed of a few years ago—a condition that, on the one hand, has made nurses more necessary and satisfactory, and on the other has given rise to destructive criticism and, frequently, resentment, not only among patients but among nurses themselves.

Let us glance at a few of the things that are happening today which have caused us to find ourselves in a spotlight of publicity.

1. Twenty-five years ago when a patient who had means to pay for service needed two, or even three, nurses all that was necessary was to put in a call and the nurses arrived. Today there are certain months of the year when even the wealthiest of patients finds it

[1] Read at the annual meeting of the Florida State Nurses' Association at Tampa, November 2, 1928, and that of the Georgia State Nurses' Association at Columbus, November 8, 1928.

impossible to get *any* nurse and immediately a cry goes out that there is a shortage of nurses. Neither these patients nor the physicians attending them are able to look in on the registry lists during another portion of the year, and find that nurses are sitting waiting for weeks at a time for the call to work. Patients become attached to certain nurses or to graduates of a certain school and when the favorite nurse is busy, a provoked clientele, together with the physician, may send forth the statement that things are not as they used to be. I answer, how can they be? Is the nursing profession the one thing that is supposedly exempt from change, in an ever-changing world?

All about us, during the last few years, people have been absorbing the lessons on prevention of disease and prolongation of life. The care of the health of workers for efficiency, purely a business proposition, has been broadcast throughout the length and breadth of the land. Nurses, like other workers, have been affected, and a family which, twenty-five years ago, had a nurse on twenty-four hour duty, giving care to a patient continuously with little or no sleep (and what she did get, obtained under poor conditions) today finds the nurse on twelve-hour duty and requiring rest under proper sanitary and peaceful conditions. Why? Primarily because no one can work adequately for more than a limited number of hours. If those engaged in manual labor alone cannot do so, how much less can the nurse who is combining manual and mental? I often wonder how much extra comfort has been given to patients and families, and even how many lives may have been saved, through extra efficiency gained by curtailing the hours of duty of the nurse.

2. Hours of duty have been limited for the health of the nurse herself—one of the workers of the world, after all, and subject to everything that affects mankind. Lastly, but of far reach, enters the question of economics.

Economics

TODAY one can obtain for a dollar bill only the worth of sixty cents of twenty-five years ago; in large cities, with high rentals, even less may be purchased for the dollar. Nurses have raised fees but have never been able to make the increase sufficient to give an adequate income, and many find themselves with little or nothing to the good at the end of the year; months of fat and months of lean have made a low average. The nurse on private duty always seems to be either overworked or idle. Nurses alone are not the sufferers. The swing of the economic pendulum has brought tragedy to families on very limited incomes, many of which have no prospect of increase. According to Warren B. Catlin, Professor of Economics at Bowdoin College, one-seventieth of the people in the United States own two-thirds of the entire accumulated wealth of the nation, whilst 97 per cent of the families live on incomes of less than $10,000 per annum. The most tragic statistic shows that 73 per cent of all the families in the United States live on less than $3,000 per year. With this figure ($3,000) a family with children can save little. When illness comes, especially if it be of long duration, the family runs into debt, since skilled medical and nursing care have to be paid for. Yet these families have been taught what modern medical and nursing science offers, and naturally, as enlightened citizens, they seek the skill advocated and find it too costly. The inconsistency of what is needed and what can be obtained makes for bitter censure.

Changes in the World

WE hear frequent comments on the extreme youth of the modern nurse. It is necessary to suggest to those who criticise, that they investigate the age of school children today. Children are entering the higher grammar school grades, and consequently going forward into high school, much younger in years than was customary a generation ago. The entrance age of the schools for nurses has to be lowered in order to try to somewhere meet the graduating age of the high-school student, and I

here give my personal opinion that a high-school diploma should be the lowest credential. Sometimes these young graduate nurses are almost libeled by patients who seek the nurse with the poise of say twenty-five years ago. Even the older graduate who is modern in all but years, frequently comes in for much criticism from families that are apt to feel that the nurse should be a person in a class all alone, not touched by the outside world. On the other hand, there are understanding patients who always seek a happy, efficient worker, taking no thought of her age but only how she herself serves.

Dr. Boudreau of the Health Section of the League of Nations, at a recent meeting of the American Public Health Association in Chicago, made me realize as never before how changed this world is. To quote:

> A few days ago in Geneva a man seated near me picked up a phone and in three minutes was talking to someone in New York. In reality we may see that the world today is only about as large as was England alone sixty years ago.

In a quickly changing world nurses, whilst keeping a steady progressive march of education and technical training, have been conservatively unchanging in their plan of employment in homes—the system remains the same. Consequently the ordinary householder, whilst accepting all the achievements of science and research, as necessarily changing life's plan, has not been led by the nursing profession to see any reason for change of ideas about the nurse or nursing.

Another feature adds to the confusion of the day. Each year more and more people are hospitalized. As each new hospital appears, or old ones add to their plants, new schools for nurses or extended old ones have been the plan. From the Bureau of Education, Department of the Interior, we have the report that forty-two new training schools have been opened since 1920 and the size of almost every old one has increased. Graduates have poured out of the schools and located in largest numbers where there were already sufficient nurses to take care of the ordinary work of the community. Thus in many places the new graduates have not been absorbed into the profession as quickly or as easily as of old.

The Grading Committee

I AM sure it is not necessary to explain the organization of the Grading Committee. Its report[2] has thrown wide the doors and let in upon the nursing profession the light of publicity. I have been informed that in some instances nurses are tremendously perturbed, others grown sad and even pessimistic because of this report and still others cannot talk about it without anger. I am sorry that it has affected any in such a way but I hope clear thinking will make such see differently. Personally I am staggered at the work ahead of us —but oh! how thankful I am that we can seek to make adjustments in the light, and not have to grope along all sorts of dark alleys of experiment. The tubercular lung is not injured by the stethoscope but is rather well served by its diagnosis and given a chance for life.

Medical Committee

IT may not be known to all of you that the physicians of this country, too, are deeply realizing the great problem of "Delivering adequate scientific medical service to all people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life." The

[2] "Nurses, Patients and Pocketbooks."

Committee on the Cost of Medical Care has a five-year program with the three following groups of studies:

1. Preliminary surveys of data, showing the incidence of disease and disability requiring medical services and of generally existing facilities for dealing with them.
2. Studies on the cost to the family of medical services, and the return accruing to the physician and other agents furnishing such services.
3. Analysis of specially organized facilities for medical care now serving particular groups of the population.

This means that a careful study is being made "into every nook and corner of the medical profession and its allies—hospitals, nursing homes, clinics, sanitariums and community health centers." The nursing profession is represented on the Committee, and there is no doubt in my mind but that nursing in general would have been surveyed by the Committee had not the Grading Committee already been at work studying the situation. We should be happy that our own national nursing organizations, and through them others, down to alumnae associations, have helped guide the work of the Grading Committee and have assisted in the report made—"Nurses, Patients and Pocketbooks." Through this report we can "see ourselves as others see us"; we can, as it were, stand outside and look in on what we have been and are doing. It would be impossible and unnecessary for me to begin to quote from that report. I say unnecessary, advisedly, because each one of you may buy a copy of the report and read it for yourself. I do wish, however, to quote the summing up of what the Committee considers the four tasks confronting the profession of nursing.

1. To reduce and improve the supply. To make a decisive and immediate reduction in the numbers of nursing students in the United States; and raise entrance requirements high enough so that only properly qualified women will be admitted to the profession.
2. To replace students with graduates. To put the major part of hospital bedside nursing in the hands of graduate nurses and take it out of the hands of student nurses.
3. To help hospitals meet costs of graduate service. To assist hospitals in securing funds for the employment of graduate nurses; and to improve the quality of graduate nursing so that hospitals will desire to have it.
4. To get public support for nursing education. To place schools of nursing under the direction of nurse educators instead of hospital administrators; and to awaken the public to the fact that if society wants good nursing it must pay the cost of educating nurses. Nursing education is a public and not a private responsibility.

Suggested Changes

THESE specific suggestions are given to us with the greatest of wisdom, founded on diligent, far-reaching research. If they are to be followed, it will mean that nurses will have to make a great many changes in their point of view and be willing to submit to experimentation. Can we change? Of course we can; all except those who have an inferiority complex or who are too old—not those old in years, but those who have attained the same result, as through age, by allowing their ideas to be permanently fixed. This may occur at twenty years or may never come, for we know many over seventy years with hearts and minds of eternal youth. We must not look for a miracle, no millennium is coming even though we give our energy and thought to needed adjustments. Even needed changes, to be of value, must come mighty slowly. Every move must be well thought out and viewed from every angle before being put into operation. A short time ago I heard one of the leaders in the nursing profession state: "We have been fifty years getting into this mess, it will take a good many to get out." It is going to need the

combined effort, conscience, desire, brains and whole-souled interest of all nurses to put our profession into the place where we want it, where we can say, "Expert nursing care *is* available for all who are sick, irrespective of social or financial status, for health teaching and demonstration for all the citizens of any given community, and the nurses themselves are economically independent."

Modern Nursing

WHAT is modern nursing? I know you will be immediately questioning: "Are you talking about institutional, private duty or public health nursing?" I answer that I am talking about all of them. There are few, if any, attributes which belong exclusively to any one group. I am firmly of the opinion that, except for certain technicalities of method, all nurses should have about the same knowledge. Every public health nurse must keep in touch with medical and surgical procedures. It is well to go back to the hospital occasionally for a medical or surgical clinic. No private duty nurse can afford to know less about health and community needs than do the families she serves. In this day and generation of Parent and Teachers' Associations, Mothers' Clubs, Red Cross Home Nursing classes, groups studying social hygiene, and community societies of every description, we have to deal with an enlightened public. The mothers of this generation have been taught a great deal about immunization for prevention of disease and in consequence they also have gained considerable knowledge about origin, prevention and care of communicable diseases. Surely it is necessary for every graduate nurse to know the theory and practical technic of modern communicable-disease nursing. It is not alone the duty of the nurse in public health to stress "disease by contact" or give lessons in prevention of blindness, there is need in the homes of the rich as well as the poor.

Every nurse needs a working knowledge of mental hygiene with consequent trained observation which detects trouble in its early stages. For real mental hygiene work most of us are as yet not fitted by training, but I believe every nurse is under an obligation to her patients to study the subject. The skill to give what is commonly known as bedside care, with good technic, is far from all that is needed by either private or public cases. There is need to understand and minister to the mental and emotional life of the patient as well. In the meantime, whilst unable to serve thus herself, the nurse should know where proper help is to be secured.

The nurse who has the privilege of entering any family should be familiar with the fundamentals of social hygiene which will make it possible, if only by giving a satisfactory vocabulary, to advise and guide. Mental and social hygiene can be treated as allied subjects and studied together.

Surely no one can question the desirability of every nurse being perfectly familiar with what we commonly call "prenatal care" and all that it means and serves. This entails reading and study and a knowledge of how to present the subject to the prospective mother, whether she belongs to an exclusive society group or is met in the rounds of the public health field.

Child care today does not mean simply the weighing and measuring of children in clinics and instruction in preparation of formulae, diets, etc. It does, of course, still emphasize the care of the physical but much more is indicated for the nurse who should be

equipped to assist in parental education. Frequently it is necessary indirectly (and less often, directly) to influence the lives of the parents themselves so that there will be a reaction on the spiritual and emotional lives of the children. No mortal has a better approach to parents than has a nurse. The nurse who has served a family through a crisis may find herself invited to accept a responsibility in the care of the children of that family, second only to that of the parents themselves. This surely needs the study of what is commonly called "mothercraft" for let no one believe that the care and guidance of children come just naturally. Let us remember that civilization itself revolves around the care and upbringing of children.

Along the same line would come a study of eugenics, the causes of juvenile delinquency and the remedies to be applied. This brings one to the question of the Juvenile Court, Children's Aid Society, Child Placement Organization, and last, but not least, the provisions of each community for unmarried mothers.

How many relief societies are functioning in the community in which you, as a nurse, work? What do you know about them? What is done for the foreigner in your midst? Do you know how to secure hospitalization for any patient requiring care, rich or poor, pay or no pay? Is it possible to secure convalescent care for those able to pay a small amount or not able to pay at all? Is there an old folks' home in which men and women who have lived together for fifty years may be cared for, without separation? How are all these organizations and institutions supported? Is there a community chest, and if so how many and what are the organizations it controls? Surely it is desirable for every nurse to know the make-up of the health department and its various divisions or bureaus. Such knowledge is not to be limited only to local activities, but should reach out to county and state which also have provided for the welfare of those in need, and can be appealed to when there is a lack locally. Without such knowledge how can she speak with any intelligence to the families with whom she comes in contact?

I maintain that these are things that should be known to all nurses. She who practices her profession in an institution, or is in private duty, or in a visiting nursing association, or who works in a municipal health department, must have a knowledge of community relationships, to offer intelligent efficient service to her employer. As there is no difference in the fundamental training for nurses so there is little or no difference in the continued studies for nurses except, as before stated, in purely technical procedures. The cultural side has to be cultivated by all; the nurse in private duty needs as clear and far-reaching a vision as does the one in public health. There is need for advice and information in the homes of those of high standing; we know that the ignorant are not all segregated in the homes which the visiting nurse enters. All nurses are really public health nurses whether they so consider themselves or not.

The recommendation of the Grading Committee relative to the reduction and improvement of students in the school of nursing must be given the most careful consideration. Surely none of us will have any objection to every effort being made to secure better qualified young women for the training schools, even though the quantity must decrease. We of the alumnae associations cannot escape a very grave responsibility for

our own schools, and we shall have to decide whether we shall attempt to influence the schools and hospitals now to act on the recommendation of the Grading Committee, or shall let time take its course and, not many years from now, find an over-supply of nurses to an extent which will prevent young women of education and culture from applying to the schools for training.

Distribution of Nursing Service

WE hear a lot about distribution of nursing service. Theoretically, a proper distribution is not difficult to achieve—nurses could be moved from large cities where they cannot secure steady employment, to other centers where the need is great; but practically it is far from easy. The majority of nurses do not care to live away from the city and if they did, what assurance can communities give them that they will have financial support or opportunity for educational or cultural development?

The Registry

I BELIEVE one of the first steps to be taken in any community is the establishment of an official registry. Such a registry should not be the responsibility of nurses alone. As a group, we of the profession have been afraid to admit either physician or employer to our conferences but with the organization of an official registry the time has come to reconstruct our ideas on this subject. The official registry should have a mixed board with physicians and representatives of the public and nurses. There is no reason why the latter—nurses—should not be in the majority. After three years on the board of an official registry, I can honestly state that both physicians and lay people can give more prestige and real constructive planning than could possibly be secured by any nursing group alone. The official registry should not only concern itself with the graduate and registered nurses of the community, but should also register the undergraduate and the practical nurse. No real thinking person can deny that the "practical" nurse is needed in a community, and the only way to control a group of persons is to have them under regulation and supervision. The registry should provide registrants with continued or supplementary education through issuing pamphlets, providing lectures and conducting institutes. The director of the registry should be a counselor for the registrants and should hold conferences periodically.

Another step in the right direction is to give to patients whose condition does not indicate constant nursing care, the services of an hourly nurse. No nurse can give an hourly service, brought within the means of the majority of people requiring it, unless she is herself on salary under some form of organization, and with limited hours of duty. The nurse working on her own must, in order to live, make her charges so high that once more the service gets into the luxury class, even though it is for convenience. The hourly nurse may be employed in convalescence, that period so much dreaded by the private duty group, when two or three hours a day will completely take care of the required service for the patient. The small apartment home used by families of moderate means prohibits an extra person at any time and in sickness this condition is intensified. Into such an environment the hourly nurse fits beautifully and thousands of families can be thus served which otherwise would have no nursing care. A full-time private duty nurse is beyond their means and out of the question

and they do not desire (for one reason or another) to employ the visiting nurse.

Group nursing in the hospitals has been talked about considerably, but very few have yet had the courage or foresight to experiment. The employment of graduate nurses and no students would tremendously improve the nursing in many hospitals and would cost no more.

Special Nursing

IN private duty, many nurses would find themselves much better off with a stated salary which would be increased with years of service or for efficiency, and which would be continuous, even though it were obtained at the cost of what many nurses term "personal liberty." The supervision of organization is dreaded by many nurses who do not understand. Supervision of graduates under organization should not be confused with supervision in schools of nursing. The word is a poor one for what we really mean is counsel.

I can conceive of an organization which will employ nurses on salary for the regulation private duty service. What this organization shall be is not at all certain and may differ in different communities. It may be a hospital, it may be an official registry, or it may be a visiting nursing association. In a rural community the most common-sense plan yet suggested is that of a community hospital from which shall radiate every type of service needed for the care of the sick and public health activities. Any such nursing organization in a rural community would eliminate most of the difficulties nurses now find whilst working out of the larger towns or cities. There would be a secured income, companionship, a group of people at all times looking after the needs of the nurse. It is always a joy to know that back of one is the organization and that one does not have to stand the fire of criticism alone. This organization would not operate for profit, but for adequate service for patients and to secure a proper income, recreation, vacation, etc., for the nurse, and in case of hospitals, for doctors also. It would naturally require capital to develop it but methods have been found for more difficult enterprises than this. In England private duty nurses have been working under organization for a generation and I do not believe the British nurse desires to make any change. The benefits of such a plan would be reflected in cities as well as in smaller communities by reducing the number of nurses waiting for work. If the nursing organization were to be a registry, or any type functioning in both rural and urban communities, the less desirable services could be divided among the nurses so that each might share in the harder tasks. You may ask, "How can we start?" "Such a thing is really impossible." I say, the answer cannot be given yet, for we have never given serious consideration to the subject, but the time is past when we may say, "It cannot be done." We can only make such a statement after an experiment has been honestly and faithfully made and failed. Until such time we are not justified in saying that an adjustment cannot be made. Since the time of the first nurses, when an ideal was inculcated so powerful as to continue a vital force, the nursing profession has heroically overcome difficulties. We, today, are capable of that courage and tenacity of purpose united with clear thinking, which has become the tradition of our kind. There will always be a certain group of free lances, as now, because patients of large income and luxurious tastes will employ

a certain number of such nurses, but I have a premonition that the bulk of nursing in the future will be under some form of combined effort if, for both nurses and patients, the pendulum is to swing back to the old comfort and happiness.

Standards

WE have discussed the economic side of the question. Let us not forget that we are a body of professional women with the responsibilities which this entails. Altruism is still a component element in the fundamental principles governing the profession of nursing, despite the gravity of the economic situation. Unless we continue to insist that the finest traits of humaneness be a prerequisite for our profession, it will deteriorate, to our shame.

All these many problems which have arisen need the most careful analysis and I think you will agree with me that there is a distinct call for leadership. Happy is that state or district which has already developed leaders; fortunate will be those who at once seek for potential leaders and offer such, scope for development. Anna C. Jammé, writing in the *Pacific Coast Journal of Nursing*, expresses far better than I could, a conception of leadership:

> Constructive leadership requires development of a thoughtful, intelligent and tolerant attitude. Good leaders are informing themselves on aspects surrounding the question they have in hand; they are fearless in expressing themselves after their ideas have undergone careful analysis and assumed concrete form. They must be animated by a spirit of give-and-take; in other words, good sportsmanship. They are unselfish and give of their time and energy willingly, and are always tolerant of the opinions of others. Let us bring before our mental vision our favorite leaders and analyze the qualities that make them our favorites. May we for a moment, and to divert our minds from the serious question of nursing, analyze a great hero of the day who may be a future leader, Colonel Lindbergh. I have no doubt but that you have done this before, and have found, as I have, that the magic word, "WE" was the index to his character which, coupled with his modesty, his sincerity, has won for him the admiration of the world.

The inference from Miss Jammé's words is clear, I am certain. Let *us* speak in terms of "WE."

About these things I hope each will think carefully for herself and not be persuaded by others without giving thought. Let us not be like the hermit crab. Let us each have our own shell and our honest opinion, even though it hurts, but let us always be open to reason and not hang on to our own opinion as tenaciously as though it came from God—that is to be a fanatic. "Amid the cheap trinkets of boasting and self-excuses, let us wear the precious stone of sincerity." Do not let us get sorry for ourselves. We all, at times, get depressed, especially those who give most of themselves, but pray as did Mrs. Wiggs on her cabbage patch, "Oh, Lord, keep me from getting sour." Nurses do not sufficiently seek other interests, and are apt to fall into a rut. Let us mix with other workers in the world, listen to their troubles and joys; in a word, "Get the other fellow's point of view."

Clear thought will follow consultation with others, often through the written word. I suggest that each read much more carefully than ever before our own magazines, the *American Journal of Nursing* and the *Public Health Nurse*. At the same time it is well not to keep one's mind *only* on volumes dealing with nursing problems, but also to get away from the subject and enjoy good literature of all ages in order to develop a vision. It has been said that "no one should use a microscope until able to see

clearly through a telescope." The perplexities of today call for determination in action—but a calm, serene repose for careful study. You may not agree with me, but I believe that for the greatest success it is necessary to develop what is so captivatingly called "charm" in person, in manner, and in social contacts, especially with those of another sphere in life than our own. Without graciousness it is difficult to attract assistance, without which no group can go very far.

I know you Southern nurses are going to do your part with resolution, patience, equable temper and generosity. Do not let worry enter, but live as the Eternal intended us to do—joyously, as one writer has framed it:

Life is a sweet thing, a gift of God who taught the sun to shine, the birds to carol, children to laugh and sing; life is indeed a thing of joy—and yet—it is also a sacred trust to be lived and used to noble purpose since in this world are many that need strength and service. So while life and strength be thine, use them forgetful of thyself and in the service of others keep the glory of youth. He that serves his fellows serves his God.

May I close with the old Spanish salutation used so often by Wilder in his book, "The Bridge of San Luis Rey"—"Go with God."

Protection of Handlers of Radioactive Materials

ELIZABETH B. BRICKERS, M.D.

SOMETHING over three years ago, the newspapers carried shocking stories of the illnesses and deaths of several women who had been working in a plant in New Jersey, painting watch and clock dials with a luminous material. . . . In all cases these workers had been employed a long time at this process before signs of injury appeared. Some of them had been working in other industries and had not been handling radioactive material for several years when their symptoms first developed. The discovery very frequently followed some dental procedure; healing at the site of the injury being delayed.

Some of the particles of radioactive material taken into the body are eliminated at once, some are eliminated gradually after the handling of the material has ceased, but in some cases the material, or a certain proportion of it, is stored in the body and continues to give off destructive emanations indefinitely.

So far it is not known what influences the deposition of the material nor how it can be eliminated. Apparently the only means of protecting the workers from the long-continued accumulation of increasing amounts is, as soon as the condition is recognized, to remove them from exposure.

The presence of this material in the body or in the air breathed out from the lungs may be determined by means of the electroscope. In addition to the general physical examination of these workers, X-ray examinations to determine any changes in the bones, and also complete blood counts should be made. A decrease of the number of white cells in the blood below 6,000 per cubic millimeter is a sign which should be regarded with suspicion. In fact, a deviation from the normal found by any one of these methods should call for immediate removal of the individual from exposure to radioactive material and for the establishment of a continued close observation of the individual's physical condition. This is particularly the case when the electroscope shows the presence of radioactive materials in the body, as this is usually the first and the most diagnostic evidence of possible danger.

Under all circumstances, where radioactive, luminous materials are used, as in dial painting, the work should be done under strict precautions. The powdered material should be handled under a hood connected with an exhaust; the painting itself should be done only where good ventilation can be obtained and maintained; and under no circumstance should the use of a brush be permitted for painting purposes, a glass or steel pen being used instead. Dial painters, or others handling this material, should be given a thorough physical examination every six months. Other persons having a greater exposure should be examined once a month.

On several occasions, recently, the Department of Labor and Industry has been called upon to give advice concerning the necessity for, and the type of, examination to be given workers handling this substance. All persons interested in, or affected by this problem are urged to take advantage of this service of the Department, or to consult directly persons equipped to make adequate physical examination of the workers handling these luminous compounds.—From *Labor and Industry*, Harrisburg, Pa., July, 1928.

The British College of Nurses

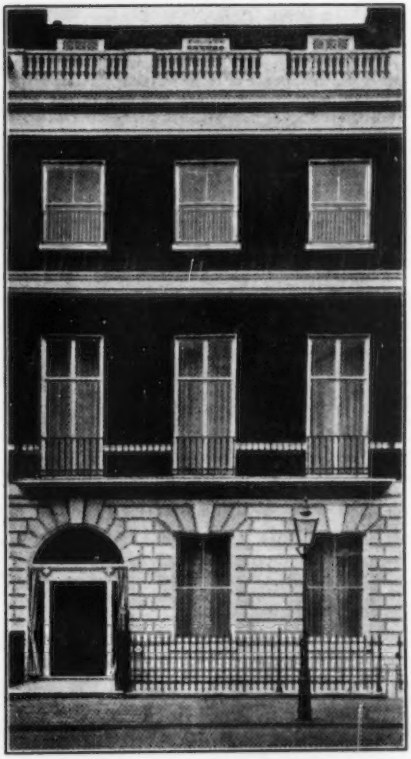
THE British College of Nurses is composed only of trained registered nurses. It was founded in April, 1926, by an endowment of 100,000 pounds from an anonymous donor, only the interest upon which is to be used for the purposes of the College. Hitherto, the work of British nurses for the organization of their profession has been hindered by the lack of funds. Now, for the first time, the means of building up a powerful association, upon a sure financial foundation, is placed in their hands. It is a great trust, a great opportunity, carrying with it its corresponding responsibility to the trained nurses of today and of the future.

Like the Royal College of Surgeons, the British College of Nurses is composed of fellows and members. The former pay an annual subscription of two guineas, and the latter an annual subscription of one guinea. Fellows and members receive a handsome diploma.

The College is governed by a president, two vice presidents, two trustees, and a council of nine, of whom six will be fellows and three will be members.

The objects of the College are to raise the general education and efficiency of trained nurses for the benefit of the sick of all classes, upon whom they will attend. It will do this, by organizing special courses of practical and theoretical teaching in nursing subjects and by holding (as the medical colleges do for doctors) examinations, of a higher standard than that for state registration, for the Diploma of Membership, and of an even higher standard for the Diploma of Fellowship of the College.

These examinations, for which examination fees will be charged, will be commenced as soon as the customary "Period of Grace" terminates.



HEADQUARTERS OF THE BRITISH COLLEGE OF NURSES
39, Portland Place, London, W. 1

Since the announcement of this splendid endowment was made in the *British Journal of Nursing* in May, 1926, a large number of fellows and members have been elected, and every registered nurse who has had three years' training at a recognized general hospital and holds its certificate, will be wise to apply at once for fellowship or membership of the College.

It is very important that trained nurses should henceforth realize that they are members of a profession recognized and controlled by the State, and that they should, therefore,

like all self-respecting professions, support their own professional organizations by their own subscriptions. The College will be able to utilize the income derived from the large invested funds in strengthening its organization, and in affording very material benevolent and educational benefits to its fellows and members.

There is no doubt that the prestige of its diploma is steadily increasing; and already it has been found that for fellows and members working abroad it has a very practical value.

Other educational advantages in the College are its varied courses of instruction and its valuable Reference Library.

The College has already founded a pension fund for fellows and members in old age and adversity; it has a defence fund, by means of which its fellows and members will be legally advised, and schemes of insurance have been carefully chosen, which will provide fellows and members with deferred annuities and other advantages and which will provide also for sickness or accident, on advantageous terms, to those who subscribe to them.

Mrs. Bedford Fenwick is President of the College and Grace Reynolds Hale is Secretary.

Suggestions for a Yearbook of Social Work

SOCIAL work is to join the other groups whose progress is recorded in a yearbook, to be issued by the Russell Sage Foundation under the editorship of Fred S. Hall of its staff. That there is demand for information each year about social work is shown by the space given to it in the three comprehensive annuals now issued—the "American Year Book," the "New International Year Book" and the "Americana Annual."

The Russell Sage Foundation will welcome suggestions from any who have had difficulty in obtaining needed current information concerning their own or allied fields of work.

Yale School of Nursing Receives $1,000,000 Gift for Endowment from the Rockefeller Foundation

THE Yale School of Nursing has received a gift of $1,000,000 for endowment from the Rockefeller Foundation, according to an announcement made by President James Rowland Angell, of Yale University.

"Coming as it does at the end of a five-year trial period," President Angell said, in making the announcement, "this gift is of great significance. It means that a novel experiment has proved a success, and an educational program for nurses, comparable to that offered in medicine, law, and engineering, is placed on a stable and permanent basis. It means further that nursing is now recognized to be of sufficient importance to warrant the existence of a school organized from the point of view of educating the nurse rather than primarily for the purpose of providing a hospital with nursing service."

Better Teeth

DECAYING teeth, says the United States Bureau of Education, are the most common defects of school children, being present in about 90 per cent of them. In bringing to the attention of school officials what has recently been learned concerning the prevention and treatment of these conditions it has published an interesting bulletin (Health Education Series, No. 20) called "Better Teeth." It states that this most common of all our diseases is due to changes which were made in man's diet as he became civilized. Certain substances essential for making sound teeth have been too scanty in our over-refined foods. Some races which have followed more closely nature's law in this respect still have good teeth. . . . In addition to proper food and feeding, better teeth for school children are dependent upon a number of things: (1) The early filling of faults in the enamel of the teeth in which decay begins; (2) the school dental clinic; (3) reparative work; fillings, extractions, and straightening of teeth; (4) proper daily care by toothbrush and dentifrice; (5) semi-annual visit to dentist for examination, cleaning or treatment of teeth.

Harmon Association for the Advancement of Nursing

A New Income Annuities Plan

DURING the Louisville convention, in June 1928, the joint boards of directors of the national nursing organizations acceded to the request of the Harmon Association for the Advancement of Nursing to appoint two members to its Board of Directors. At the personal request of Mr. Harmon,[1] S. Lillian Clayton, President of the American Nurses' Association, and Carrie M. Hall were appointed to help in reconstructing the plan. These two nurse representatives have met monthly, since September, with the Harmon Association Board in New York. The problems of developing and extending the plan with the object of serving the greatest possible number of registered nurses during old age have been discussed from every angle.

The Harmon Association now offers to the registered nurses of the country a retirement income annuities plan on a group basis which is simple and sound. While a deferred annuity does not provide economic security for those who are now in advanced years, it does offer to the young nurse a means of safeguarding her future with a permanent income if she does her part by making the required small monthly deposits during her working years. The question of incorporating disability insurance with the Plan has been given careful consideration. It has seemed wisest to adhere to the original purpose of the founder and concentrate solely, at this time, on the development of old-age protection through the proposed income annuity.

The payments of income from annuities through the Harmon Plan are guaranteed to members by the Metropolitan Life Insurance Company.

The Plan does not differ greatly from the kind of deferred annuity which any individual may secure through many insurance companies, but it has several unique features, one is that in the administration of the Group Plan it is anticipated that in future years there may result from excess earnings and other sources a considerable increase in annuity payments beyond the guaranteed sum. For in the Harmon Association we have an incorporated body capable of receiving gifts, legacies, endowments, and funds from other sources with an organization for administering such funds for the benefit of nurses in the Plan through increased annuity payments.

Only registered nurses are eligible for membership. No physical examination is required. Participation of the employers of nurses is not essential to the success of the Plan. Deposits of $5, or multiples of $5, must be made monthly. Deposits may be increased or decreased to meet changing circumstances, a flexibility which should be appreciated by nurses. The more that an individual can deposit during her productive years, the greater will be her income on retirement. If necessary to cancel the Income Annuity, members may withdraw deposits in full in cash. There is also an alternate plan which provides for withdrawal of deposits with interest, but with a smaller guaranteed income if one stays in the Plan to maturity.

The Harmon Association Plan does not offer a solution for all the problems of advancing years, disability and lack

[1] William E. Harmon died July 15, 1928.

Examples of What Some Members Are Now Doing

Member	Territory	Position	Age on Entering Plan	Amount of Monthly Deposit	*Annual Amount of Income Annuity from Two of the Optional Dates	
					Age 60	Age 65
Miss "A"	Pennsylvania	Institutional	23	$5.00	$399.00	$638.40
Miss "B"	South Carolina	Public Health	25	5.00	356.40	571.20
Miss "C"	New York	Private Duty	25	10.00	712.80	1,142.40
Miss "D"	New York	Private Duty	30	5.00	264.00	428.40
Miss "E"	Massachusetts	Private Duty	30	15.00	792.00	1,285.20
Miss "F"	New York	Private Duty	31	15.00	743.40	1,209.60
Miss "G"	New Jersey	Director	32	5.00	232.80	379.20
Miss "H"	Connecticut	Private Duty	33	5.00	217.80	357.00
Miss "I"	Michigan	Hospital Nurse	34	5.00	204.00	335.40
Miss "J"	Vermont	Private Duty	37	15.00	496.80	828.00
Miss "K"	South Carolina	Public Health	40	5.00	132.00	225.00
Miss "L"	Oregon	Hospital Nurse	40	10.00	264.00	450.00
Miss "M"	New York	Res. Director	40	15.00	396.00	675.00
Miss "N"	Pennsylvania	Hospital Nurse	42	15.00	336.60	593.20
Miss "O"	Ohio	Supt. of Nurses	42	25.00	561.00	972.00
Mrs. "P"	Massachusetts	Asst. Supt.	45	15.00	257.40	462.60
Miss "Q"	Connecticut	Private Duty	48	10.00	126.00	236.40
Mrs. "R"	Wyoming	Private Duty	49	15.00	167.40	324.00
Miss "S"	Tennessee	Dir. of Nursing	50	15.00	149.40	295.20
Miss "T"	Connecticut	Visiting Nurse	54	25.00	132.00	318.00

*NOTE—The above Annuities are guaranteed and will be paid to the members monthly, by the Metropolitan Life Insurance Company, the monthly payment to the member being one-twelfth of the annual amount.

of employment of the members of the nursing profession. It does offer a sound solution to one phase of the problem for the group of younger nurses now in active work. It has the endorsement of the officers of the national nursing associations and it is hoped that thousands of nurses will avail themselves of this opportunity to provide for old-age protection. Information can be secured from the office of the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, New York City.

Following is the new announcement which was approved by the joint boards of directors of the national nursing associations at a meeting held in New York on January 16, 1929.

Retirement Income Annuities Plan

Those Eligible

If you are a registered nurse, you are eligible for membership in the Harmon Association and its Retirement Income Annuities Plan.

Membership Dues

The annual membership dues of the Association are one dollar. Your dollar is used to pay part of the administration expenses of the Association and to enable it to institute other activities of benefit to the profession of nursing.

Monthly Deposits

Each member who joins the Retirement Income Annuities Plan makes a deposit of at least $5 a month. The amount of your monthly deposit may be $10, $15, $20 or more (any multiple of $5), according to what you can afford to deposit and the size of the Income Annuity you desire. The amount of monthly income secured by your deposits depends directly on your age at the time of joining the Plan and on the size and the number of your deposits.

Optional Dates for Start of Income

As a member, you may elect to have your Income Annuity mature and your income from it start at any age between 50 and 65. A few examples of Income Annuities that are anticipated by several members of the Association are shown in the accompanying list, the income from the annuities beginning at age 60 or 65, two of the optional maturity dates. Should you desire to have your income from your annuity start before the age of 60, you will receive a proportionately smaller monthly income than those incomes beginning at later ages. The later you have your income from your annuity start, the larger it will be. The optional maturity dates give the Plan a degree of flexibility which is highly desirable for the profession of nursing, so that you can have your income from your annuity begin early or late, entirely in accordance with your own particular circumstances. When joining, you do not have to decide upon the date at which you desire your income to start. You may make this choice at any time.

Additional Annuity Payments to You

Because this is a *group* annuity plan, annuity payments to members may be considerably increased over and above the contractual amounts by additional annuity payments to members that may result from excess earnings in the administration of this Group Plan or from surplus funds of the Association arising from any other source.

Annuities from Single Deposits

In addition to your regular monthly deposits, you may deposit whenever you have larger funds available, single deposits of fifty or more dollars, for the purpose of purchasing, through a single payment, Income Annuities that will further increase your retirement income. This privilege is of particular value to those who have already spent a considerable number of years in the profession without previously making preparation for a Retirement Income.

Flexible Deposits

You may increase or decrease your monthly deposits, to meet changes in your circumstances, providing that you make such future changes in your deposits in even multiples of $5. The more you can deposit during your productive years, the greater your income when you retire.

Deposits Always Yours

In case you should wish to cancel your Income Annuity and to withdraw your deposits, you can receive the amount of your deposits *in full in cash*, at any time you request them, if you make such request before you begin receiving an income from your Income Annuity.

Alternate Plan

An alternate Plan including the return, in case of withdrawal, of all deposits with interest, with consequently smaller annuity values, is available also, if this option is chosen at the time of joining the Association. The following several examples show the effect of the two withdrawal privileges on a monthly Income Annuity, resulting from a monthly deposit of $10, the deposit begun at various ages and continued to age 60, one of the optional ages for beginning the income.

If You Stop Nursing

Should you, at any time, withdraw from the Profession of Nursing, you can either withdraw all your deposits in cash, or leave them in the Plan, make no further deposits, and receive, from the maturity date, whatever income from the annuity that the deposits you have made will provide; or, you can continue making your deposits and receive the same income from your annuity you would have received had you remained in the Profession of Nursing.

Age on Entering Plan	Monthly Amount of Income Annuity	
	Alternate Plan With Privilege of Withdrawal of Deposits With Interest	Standard Plan With Privilege of Withdrawal of Deposits Without Interest
20	$58.40	$78.60
25	45.50	59.40
30	34.80	44.00
35	25.90	31.80

Loans

At any time during the period you are accumulating your annuity, you have the privilege of using your Certificate Book as security for a loan from a bank or other available source, for an amount which, with interest, will not be greater than the total of your deposits.

In Case of Death

Should you die before you begin to receive your monthly income, the total amount of your deposits will be paid immediately to your estate, or to any person you may have named as your beneficiary. Should you die after you have begun to receive your monthly income, but before an amount at least equal to your total deposits has been paid to you, the full balance between the income you received and the deposits you made will be paid at once to your estate or the beneficiary you selected.

Trustees Help Safeguard Plan

The government of the Association is in the hands of a Board of Trustees elected by the members of the Association. The Trustees, under the Constitution and By-Laws, can receive no financial compensation for their services. The nature of the Association has enlisted the coöperation of Trustees who are connected with some of the most outstanding financial organizations in America, experts in law, banking, life insurance and annuities, as well as hospital and nursing organization executives, and the leaders in several of the largest organizations for social service in the country.

Table Showing the Amounts of Income Annuities

Annual Annuities for women, payable monthly from age 60 for life, derived from the monthly deposits of members

Age of Member on Entering the Plan	Annual Income Annuity from $5.00 Deposits of Members	Annual Income Annuity from $10.00 Deposits of Members	Annual Income Annuity from $15.00 Deposits of Members	Annual Income Annuity from $20.00 Deposits of Members
18	$525.00	$1,050.00	$1,575.00	$2,100.00
19	497.40	994.80	1,492.20	1,989.60
20	471.60	943.20	1,414.80	1,886.40
21	446.40	892.80	1,339.20	1,785.60
22	422.40	844.80	1,267.20	1,689.60
23	399.00	798.00	1,197.00	1,596.00
24	377.40	754.80	1,132.20	1,509.60
25	356.40	712.80	1,069.20	1,425.60
26	336.00	672.00	1,008.00	1,344.00
27	316.80	633.60	950.40	1,267.20
28	298.20	596.40	894.60	1,192.80
29	280.80	561.60	842.40	1,123.20
30	264.00	528.00	792.00	1,056.00
31	247.80	495.60	743.40	991.20
32	232.80	465.60	698.40	931.20
33	217.80	435.60	653.40	871.20
34	204.00	408.00	612.00	816.00
35	190.80	381.60	572.40	763.20
36	177.60	355.20	532.80	710.40
37	165.60	331.20	496.80	662.40
38	154.20	308.40	462.60	616.80
39	142.80	285.60	428.40	571.20
40	132.00	264.00	396.00	528.00
41	121.80	243.60	365.40	487.20
42	112.20	224.40	336.60	448.80
43	103.20	206.40	309.60	412.80
44	94.20	188.40	282.60	376.80
45	85.80	171.60	257.40	343.20

NOTE.—The above Annuities are guaranteed and paid by the Metropolitan Life Insurance Company to the members monthly, the monthly payment to the member being one-twelfth of the annual amount.
For information for ages over 45, write the Harmon Association.

Future Income Guaranteed

The Trustees, wishing to surround the Plan with the greatest possible safety, selected the largest financial institution of its kind, the Metropolitan Life Insurance Company, as the first to guarantee the payments of income to members from their annuities under the Plan.

Certificate Books

When you become a depositing member you will receive a Certificate Book, issued by the Metropolitan Life Insurance Company, or a similar insurance company approved by the Board of Trustees. This Certificate Book constitutes a definite contract and guarantee by the insurance company not only that the designated payments will be made to you promptly, but also that your income will never be less than the amounts guaranteed for such deposits as you make.

Income Checks Mailed Monthly

From the annuity maturity date you select, year after year, as long as you live, you will receive your monthly income check direct by mail.

You Can Join Now

You can start today in a systematic, sound and guaranteed plan, making your monthly deposits by mail, toward an Income Annuity which will begin to work for you immediately and which will furnish a guaranteed permanent income, year after year, when you yourself can no longer work. It is at that time that an absolutely dependable and regular income is most needed and valued. No medical examination is required. Simply fill out the Application form of the Association, and mail the Application to the New York City office of the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, with the annual dues of $1 and your first monthly deposit.

What You Can Accomplish

Above are printed Income Annuity tables, showing what you, yourself, can accomplish

from your own deposits, provided they are begun at your present age. All Annuity rates being based on age, they will never again be as advantageous to you as they are at the present moment.

This Plan aims directly at creating *maximum benefits for you* at a time in life when you will most need a regular monthly income which is absolutely permanent, a guaranteed income for old age, when other financial resources often have ceased to exist.

Only an annuity can *guarantee* future monthly annuity payments to you until the very last month of your life. The annuity payments under this Plan are *guaranteed.*

Because the guaranteed annuity payments may be further increased from excess interest, surplus, and other sources, the eventual benefits to you should be substantially greater than those of the usual type of annuity available to the individual nurse outside of this or a similar organization of nurses.

Important Features for You in This Plan

1. A permanent monthly income *for your own use,* which, once begun, continues throughout the remainder of your life, regardless of how long you live.

2. No medical examination required under the Plan.

3. Convenience to you in accumulating your fund and in your receipt of income checks.

4. No loss to you or forfeiture of any of your deposits. No "surrender charge."

5. Absolute safety for your investment.

6. In case of any emergency, the privilege of borrowing against or of withdrawing all of your deposits at any time that you may wish, previous to the beginning of the annuity payments to you.

7. In case of your death, the immediate cash payment to your beneficiary of the full credit balance on your deposits.

8. An organization through which funds from legacies, endowments, gifts, excess interest, or other sources may be administered for your benefit.

9. Membership in an association organized to assist registered nurses, guided by your own trustees and officers chosen by the members themselves.

Influenza Canteen and Diets

BERTHA M. WOOD

IN Boston, at the time of the influenza epidemic of 1918, the Boston Dispensary closed its doors to patients but kept the Food Clinic open as a canteen from which soups and broths were ordered by the visiting nurses and district doctors. After many quarts of broth and soup had been distributed, it was discovered that a large quantity had been left untouched by the patients.

This was due to two factors: First, there were many nationalities represented among the patients; the broths and soups were American-made and were not to the taste of some of the foreign-born patients; also it was no time, when ill, to learn to eat new foods. The result was that the foods were frequently left untouched which meant that they were of no therapeutic value. These facts led to the second reason. The patients realized that there was little virtue in taking these two foods and so they waited until they were able to have their accustomed diet.

The following year, when influenza cases occurred, both physicians and dietitians had learned the value of fruit juices and these were administered. The patients enjoyed them, as fruit juices are acceptable to all nationalities, and their value in treatment is well-known.

Usually there is a temperature or fever during an attack of influenza. This depletes the body tissues. As about two-thirds of the total weight

of the body is made up of water, much of the loss of weight in acute fever is due to increased dryness of the body, and its very rapid restoration during convalescence is due to retention of water in the tissues. By using fluids as food during the fever stage, the water content contributes to the reserve needed.

Another advantage of using fruit juices is the fact that the kidneys are not overloaded with nitrogen waste from nitrogenous foods. It is a temptation to supply a large amount of protein in the diet of a patient with fever to replenish the body tissues. It has been observed that it is impossible to bring about a condition of nitrogen equilibrium in acute fevers on any feasible quantity of food.

The consumption of much nitrogenous food has also the disadvantage of tending to bring about a condition of toxemia, while fruit juices help to clear the blood of the toxic condition, a fact which is most valuable.

Taking food in the form of fluids is not merely gratifying to a thirsty, feverish patient but it eliminates the necessity of mastication, which the diminution of the salivary secretion renders difficult.

Fruit juices furnish not only mineral matter to rebuild bone and tissue for the fever patient, but also they are a source of sugar which is easily absorbed into the blood to furnish energy to combat the disease.

The use of various fruit juices has proved to be not only more pleasing to the patient but of greater therapeutic value, and last of all there is no waste of effort on the part of the nurse in preparing food not consumed.

Recipes [1]

Lemonade

1 cup of lemon juice — 2 cups of cold water
2 cups of syrup

Orangeade

1 cup of orange juice — 1 cup of cold water
½ cup of syrup

Pineapple Lemonade

½ cup of lemon juice — 1 cup of cold water
1 cup of syrup — 1 cup of pineapple juice

Cherry Lemonade

½ cup of lemon juice — 2 cups of syrup
1 cup of cold water — 1 cup of cherry juice

Raspberry Fruit Punch

1 cup of orange juice — 2 cups of cold water
1 cup of lemon juice — 2 cups of syrup
2 cups of canned raspberries

Fruit Punch

1 cup of lemon juice — 3 cups of pineapple juice
3 cups of orange juice
2 cups of syrup — 4 cups of cold water

Fruit Punch with Ginger Ale

1 pint of ginger ale — Juice of 8 oranges
Juice of 3 lemons — 1 cup of syrup
More sugar if desired

Grape Juice Punch

1 pint of grape juice — ½ cup of lemon juice
3 cups of syrup — ½ cup of orange juice

Iced Tea

This can be served with lemon and sugar, or with mint leaves. Many are fond of a generous supply of lemon in it.

Grape juice can be added to any other fruit punch if one desires.

Ginger ale makes a delightful addition to almost any fruit drink.

Other recipes may be found in the August, 1928, issue of the *American Journal of Nursing*.

[1] "Food, Nutrition and Health," by E. V. McCollum, Ph.D., Sc.D., and Nina Simmonds, Sc.D.

Nurses' Residence

At Lincoln General Hospital, Lincoln, Nebraska

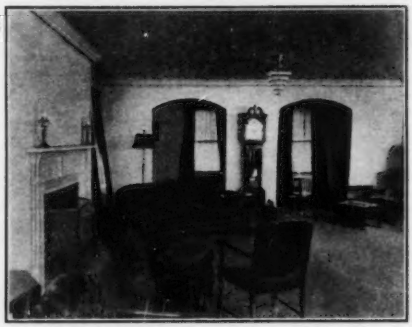
MRS. GLADYS SMITS, R.N.

ANOTHER new nurses' residence in the mid-west was opened for occupancy in December when the Lincoln General Hospital Board of Managers gave an informal tea to announce the completion of their project. The donor of the handsome new building was John L. Teeters, President of the Hospital Board.

The home and hospital are located on the same campus, a half block apart. The building cost approximately $85,000. It is a three-story fire-proof structure of brick, with living accommodations for seventy-five. The home with its surrounding grounds occupies a quarter of a block.

In order to ensure beauty and grace, many reproductions of colonial furnishings are in evidence. The design is in the Georgian style, with the entrance an exact copy of an early colonial home which still stands in Alexandria, Va.; while the ends of the building are similar to the early home of John Hancock in Boston. From the entrance one again sees the influence of early American days, in the furnishings and in the quarry tile of the lobby and vestibule.

LINCOLN GENERAL HOSPITAL NURSES' HOME



A Corner View of the Large Parlor

The corridors are laid with battleship linoleum in order to promote silence. The north corridor leads into the large parlor, which has alcoves. This room, thirty by forty feet, has a western, northern and eastern exposure, and with its decorative scheme of taupe and rich dark garnet reflects a pleasing air of quiet and rest. The crystal chandeliers and candlesticks (replicas of the chandeliers), the garnet velour hangings, the standing lamps in harmonizing colors, the tapestry-covered chairs, the overstuffed lounges, the grandfather's clock and the large modern colonial fireplace with its background of red brick and ivory mantel, all portray a comfortable homelikeness. The south corridor leads to the Superintendent's suite, which has an eastern, southern and western exposure. On the main floor are suites for the faculty members and also a guest room.

On each floor there is a local linen room, a closet for cleaning equipment, a fountain in the hallway, chutes to the incinerator and the laundry room, a marble bathroom containing four showers and one tub, a completely furnished kitchenette, and a living-room for informal gatherings of students.

On each of the second and third floors is a suite for graduate nurses and the students' rooms. These are equipped with a lavatory, above which is a recessed metal cabinet, a specially designed study table for two, with a reading lamp attached, two study chairs, an easy chair, a dresser and a closet. The latter is well planned with rods, shelves and shoe racks. The hardwood floors are covered with rugs. Windows drapes have been selected by the students and each room expresses individuality.

In the basement is a large recreation room forty by fifty feet. The walls with their green finish, the alternating squares of green and gray terrazzo floor; the colorful curtains lend a festive air to the students' gatherings. A telephone, radio, piano and victrola are at the disposal of students at their leisure. Adjacent to this room is a serving kitchen and two dressing rooms.

Student Nurse's Room

Throughout the new building there are many evidences of careful planning, in order to secure the maximum beauty and utility at a reasonable cost. An effort has been made to create, in every possible manner, the atmosphere and comfort of home. It has been planned with this ideal in mind, that it may be a real home for the nursing personnel of the Lincoln General Hospital School of Nursing.

The Status of Nursing among the French Canadians of the Province of Quebec[1]

REVEREND SISTER AUGUSTINE, R.N., EDITH B. HURLEY, R.N., and MADAME RACHEL BOURQUE, R.N.

THE history of the nursing profession in our country goes back to the year 1639, under the French domination. During that period the ladies of the court of Louis XIII were greatly interested in social work. Thanks to the "Relations" of the Jesuits which were read with eagerness, they knew the pressing needs of the Colony still in its infancy. Madame la duchesse d'Aiguillon, niece of the Cardinal de Richelieu, whose zeal equalled her piety, resolved to furnish the necessary funds to build in the city of Quebec a hospital destined for the colonists and the Indians, as the savages of the country are called.

Three nuns, nursing sisters of Dieppe, of the order of the Chanoinesses of St. Augustin, were chosen for this heroic enterprise. In company with the first group of Ursuline nuns, among whom was Mother Marie of the Incarnation (who was called the Térèse of New France), they arrived at Quebec on the first of August after a frightful voyage of three months. At this moment an epidemic of smallpox broke out among the Hurons; the nursing sisters, lodged temporarily by the Jesuits, put themselves to work immediately and in less than three months they had given care to more than two hundred of these unfortunates whose filth was equalled only by their misery.

A life of unheard-of sufferings and privations began for the group of noble women, which was to be theirs for more than a century. Their unconquerable courage, their great charity, were above everything. Extreme poverty, the cruelty of the Iroquois, fire, war—nothing could conquer their devotion.

In 1642 occurred the founding of Ville-Marie, today Montreal, 180 miles from Quebec. The distance of the borough of Hochelaga (the Indian name for Montreal) from that of Stadaconna (the Indian name for Quebec) necessitated the establishment of a new hospital, that of the Hôtel-Dieu of Montreal. The same sublime devotion, the same heroic sacrifices that were so admired at Quebec surrounded the cradle of Ville-Marie.

To the great Jeanne Mance (the collaborator of Maisonneuve), whose ability and qualities we know, was entrusted the direction of the new hospital. She is the first woman who appears in the origin of Ville-Marie (Montreal). With her noble heart, her sound judgment, her enterprising spirit, her firm will, and her heroic virtues, she is the fine pure type after which her followers are modeled. She associated with her the nursing sisters of la Flèche to help her and to continue her work.

The history of these noble and ancient institutions is the history of Montreal, of its heroic origin, of its stirring struggles, of its astonishing progress.

Since that remote period the number of our institutions has increased considerably. We have today, in the province of Quebec, fourteen hospitals whose schools of nursing are approved by the Association of Registered

[1] A somewhat abbreviated form of an article prepared for the *I. C. N.*

Nurses of the Province of Quebec, without counting a good number of others, especially in the district of Quebec, which have not yet had their schools approved and their graduates registered.

The Association of Registered Nurses of the Province of Quebec dates from 1920 when it was legally approved by the Legislature which granted it a charter. In 1925 the law authorized the Association to make obligatory an examination preliminary to entering the Association. This examination, under the direction of the Committee of Management of the Association, is given twice a year for the graduates of all the approved schools. The law makes an exception for the graduates of the Schools affiliated with one of the French Canadian Universities of the Province, in which case the Board of Examiners is composed of members of the University and members of the Association.

The first school of nursing among the French-Canadians was founded at the Hospital Notre Dame in October, 1899. The hospital itself was due to the initiative of Dr. P. Lachapelle, the reverend Father Rousselot, P.S., and the Mother Superior General of the Gray Nuns, Mother Deschamps.

We see here united in a common undertaking to establish a national and Catholic enterprise, the University, the order of Saint-Sulpice and the Gray Nuns. It is on this triple foundation that an institution rests which has its place with us and its reason for existence—and which should realize under a form of charity unknown up to that period an intimate religious and secular collaboration.

The School of Nursing was founded with the object of doing charity work and for clinical teaching; in its development it had necessarily to extend its benevolent action to young women wishing to learn the art of caring for the sick.

This school, as well as the Hospital of Notre Dame itself, is under the direction of the Gray Nuns. These worthy daughters of the venerable Mother d'Youville lead a quiet existence but they have nevertheless a remarkable spirit of progress and their devotion to duty is so familiar to us that it passes unperceived.

The second French-Canadian school of Nursing in Montreal was founded at the Hôtel-Dieu Hospital in 1901 and received its legal existence in 1920. Its affiliation to the Association and to the University of Montreal gave it the last official approval.

In 1907 the third School of Nursing was opened, that of the Hospital Saint-Justine.

It was on a November day, when the leaves were falling from the branches like wounded birds, that some ladies met together in an old house. They had $87.11 in money, a box for a table and four chairs with which to lay the foundations of the Saint-Justine Hospital for Children. These early workers had a heavy task to accomplish; to undertake to organize a hospital for children at this period was to fight against fixed prejudices. It was considered that children ought to be cared for in their families or if necessary with adults in the existing hospitals. Because it was necessary to fight against these prejudices and because there were little ones who wept and asked for help, a week later a bed, a ton of coal, a sick child and a nurse entered the old house simultaneously. The Saint-Justine Hospital was founded.

The medical department of the Saint-Justine Hospital, under the direction of Dr. Raoul Masson, was organized in January, 1908, and the dispensary opened in March of the same year. Already there were many mothers coming to the consultations with their little children pressed against their breasts.

In March, 1910, the "Filles de la Sagesse" arrived from France to cooperate by their devotion and their charity in the fine work of Saint-Justine. This hospital has today 300

beds for children, excellent dispensaries, a maternity department and a School for Crippled Children. This work is eminently humanitarian since it contributes to the reduction of infant mortality and it is a work of national coöperation.

From Montreal, let us go to the city of Three-Rivers, 96 miles lower on the north shore of the great Saint Lawrence River, where we find the fourth School of Nursing. This school is annexed to the St. Joseph Hospital under the direction of the Sisters of Providence, a community founded in Montreal in 1843 by the great Bishop Bourget and Madame Gamelin. This community, modeled on that of the Sisters of Charity of Saint-Vincent-de-Paul, was founded for the relief of all sorts of human misery. The sick of every category, foundlings, old people, orphans, deaf and dumb, incurables and mental cases find in the 102 establishments of the Sisters of Providence scattered throughout all North America, the care necessary for their cure; or refuge, protection and a home.

The School of Nursing of the Hospital of St. Joseph at Three-Rivers is affiliated to the University of Laval in Quebec and approved by the Association.

In October, 1912, another School of Nursing (the sixth) opened its doors to devoted women of ideals. It was the School of the Hospital of Saint-Jean-de-Dieu, an establishment under the direction of the Sisters of Providence. More than 3,500 mental cases are hospitalized in this institution. Of this number more than 600 are under treatment in the different medical and surgical services for the care of physical sickness. The pupils of the school receive a complete training comprising the two months' affiliation they have at the Saint-Paul Hospital for contagious diseases and the Hôpital de la Miséricorde for Maternity Training. The school is approved by the Association and affiliated to the University of Montreal. It is well organized and contains the most modern material for the education of its pupils.

Let us return for the history of the fifth school to Montreal to the Hôpital de la Miséricorde, an institution founded in 1846 by Monseigneur Ignace Bourget, bishop of Montreal and Madame Jetté, known in religion as Mother Marie de la Nativité. In the beginning the hospital did not have a school, so Madame Perras, a charitable widow, offered her services to the institution which accepted them with gratitude. Several hospitals sent their pupils there in order to give them the training needed in obstetrics and in this way the teaching of pupil nurses began.

Gradually the institution agreed to receive pupils desiring to specialize in obstetrics and the school was established. As this hospital now offers general training, its school was approved by the Association in 1925 and affiliated to the University. The Hôpital Général de la Miséricorde also bears the title of "The Catholic Maternity Hospital of Montreal."

The seventh School of Nursing is found in the city of Three-Rivers at the Normand and Cross Hospital. The hospital opened its doors in 1912 and the school was founded at the same time. It is approved by the Association and the University of Laval of Quebec.

In the city of Sherbrooke, situated in the Eastern Townships, we find the eighth School of Nursing, in the Saint-Vincent-de-Paul General Hospital, directed by the Sisters of Charity of Saint-Hyacinthe. The courses for nurses were inaugurated in 1913. Like the preceding schools it is approved by the Association and the

University. The city of Sherbrooke feels itself rightly honored in possessing a hospital which, although distant from Montreal and Quebec, the centers of university teaching, offers to its pupils every facility for a complete training.

The little town of Lachine in the suburbs of Montreal gives us the ninth School of Nursing, which is that of the St. Joseph Hospital, directed by the Sisters of Providence of Montreal. This little hospital has already seen hundreds of sick received under its hospitable roof who have there found again health and happiness. The attractive little maternity department allows the pupils to get their training in obstetrics without having to go elsewhere for it, which is an advantage greatly appreciated.

In all these schools the program of study is that prepared and required by the Committee of Management of the Association of Registered Nurses of the Province of Quebec which requires 303 hours of theory, one-third of which are devoted to principles and methods of nursing.

This program comprises three years of study and some months of affiliation in general or special hospitals (according to conditions), so as to complete the training of the pupils.

The greater part of the hospitals of the French language are directed by the nuns of various communities and have their own schools, as a result of which graduate lay nurses find in these hospitals only rare positions. Up to 1925 private duty was almost the only field open to lay nurses.

However, in 1925, the University of Montreal with the aid of the Provincial Government, that of the Health Department of the City of Montreal as well as that of the Anti-Tuberculosis and General Health League of Montreal, and also the help of the Metropolitan Life Insurance Company, founded its School of Public Health Nursing.

This school gives a postgraduate course of nine months to graduate nurses from the Schools of Nursing approved by the Association and affiliated to the University of Montreal. It has as object the training of public health nurses whose need is greatly felt in the Province.

The school's graduates are filling important positions. The number of its pupils is increasing each year to such an extent that it has been necessary to limit the number of applicants accepted.

In the Province of Quebec are presented special problems similar to those encountered in Belgium, due to the fact that here two races, speaking two different languages, meet. But it is to the honor of the Association to have known how to unite in its membership nurses of these two languages. Its administrative council is composed of members of these two groups who understand each other very well and whose relations are most friendly.

The distinguished visitors who will do us the honor of attending the International Congress can see for themselves how much the French-Canadian nurses are interested in their splendid profession, how much they desire its progress and its improvement, from the moral point of view as well as the professional and patriotic.

We give our honored guests the most cordial welcome and we hope that they will have only pleasant memories of their sojourn with us to carry back to their countries.

Spiritual Independence[1]

THOMAS HAYES PROCTOR, Ph.D.

ALTHOUGH I have no special competence to address you on professional subjects, my feeling is that you are more than nurses—you are human beings with a human life to live and its general problems to face and, therefore, I may perhaps be able to bring you some message on the more general subject of living, which will have some bearing on your needs. The subject I have chosen is "Spiritual Independence." I have chosen this because it is my conviction that it is a message specially needed by our age, and perhaps specially needed by you as you face life.

One cannot but be struck by the amount of unhappiness and discontent of the present day. So many people belie the promise of their youth. Times of ease and of prosperity seem to make for more unhappiness and more discontent. I want to warn you against two common errors which seem to be made amongst the people of today.

The first error is the error of thinking that happiness is ever given to anybody. We are brought up so often with the superficial optimism, not based upon the facts of life or the facts of the world, but upon romantic stories we have read, in which the hero always marries the beautiful heroine and everybody gets exactly what he wants. And there is so much, particularly in this country, of that false optimism, that we are brought up to the idea that happiness is something that is given to us. Happiness is not given. Happiness has to be attained.

The second error, I believe, is a misinterpretation of what constitutes success in life. We are also brought up on the doctrine that to succeed means to possess—that the more things we have, the happier we are. This seems to be the implicit philosophy of our age, making our age contrast with other ages of the world.

I might express modern philosophy in the two words "Production" and "Distribution." The production of more things, the making of more goods, and more equable distribution, are essential to the philosophy of our present civilization. This philosophy is certainly better than fatalism, better than the passive resignation which accepts the decisions of the powers of the universe, without question. When I was in Egypt, I used to see very commonly, children in the arms of their mothers, and the children's eyes would be covered by flies which the mothers would not attempt to drive away, because they would only come back again. That sort of resignation, that passive acceptance of fate, is unworthy of human nature. It would be better to rebel against fate, even though doomed to failure; better to try, even though we lose; better to make the effort, even though there is no possibility of success, and we often pride ourselves upon that very quality in our civilization that has made us unwilling to accept things as they are, but has made us strive to make them over nearer to the heart's desire. That is better than that sort of philosophy which would say the things of the world are not real things. I think we can be proud of the spirit of our age's philosophy which depends upon the possibility of good. The things of this world are good things. The things that are made by our industrial

[1] Address given at graduation, October 29, 1928, Peter Bent Brigham Hospital School of Nursing, Boston, Mass.

civilization are good things. Some of them mean greater control over our environment, they satisfy desires, they give greater opportunity for self-expression, they give more power. Take, for instance, the difference between the modern grand piano and the old-fashioned spinet. None of the great artists of today would want to go back to the time when there was no grand piano. The things that are made are good things. It is one-sided to condemn industrial civilization, as is so often done. Especially would I like to emphasize that our industrial civilization, seeking for the control of nature and conquest of fortune, has given rise to one of the greatest of man's achievements. It has given rise to modern science which you, in your capacity, represent. The achievements of modern science, its objective viewpoint, its long and patient research, cannot but be highly praised. The heroes of science compare favorably with the heroes of any army, and I do not think the world has ever seen anything in human effort greater than the rise and progress of science. Not only in science, but in the faithfulness of work, in the devotedness of labor, we have real spiritual value. It is one-sided to condemn industrial civilization. The effort to achieve so much, the effort to overcome dirt and disease, the effort toward more equable distribution—all this is noble. It has, on the whole, meant more bread, more beauty, more movement, more color, more happiness, and a wider and fuller life.

But if it is one-sided to condemn industrial civilization, it is still more one-sided to think that in that civilization, you may find the solution of all human problems. For the problem is two-sided. There is the thing we want and there is the desire that clothes that thing with goodness, so that, in the very nature of things, we need not only control over nature and fortune, but control over ourselves, and the simple truth is that, as a matter of fact, happiness comes more through self-control or in achievement of spiritual independence, than it does through the control of fortune and possession of things. It is very simple to convince you of the truth of this, for our control over fortune is necessarily limited. We do not live in a world in which you can expect happiness as a right, but in a world of necessary limitation. We can perhaps look forward, through progress, to supply the bare needs of life, to the time when there shall be enough food for everybody, and houses, and when we shall have accomplished much in the conquest of disease. We could do very much more than we have dreamed of doing if we once made human goodness our aim and organized life for the sake of happiness.

But I would remind you that you simply cannot have all that you want. Some of you will not get the promotion that you want. It is very often said that there is always room at the top, that is, for one person, and for one only. You may fail of health. You cannot stay the stars in their courses, and you cannot escape from this universe which is not altogether made to answer to our desires and which is often reckless of our fortunes.

Sickness and death are ever present. There is tragedy in the world. It is a world in which there is and must be tragedy. Success is not always in our power. I think that one of the things upon which you are especially to be congratulated is that you have had the education which has brought you face to face with the sterner things of life. The penalty of having illusions is that sooner or later you are bound to be disillusioned. It is better to get

rid of your illusions while you are young before you go out into the world. You cannot altogether control fortune.

Furthermore, human desires are illimitable. This is the paradox of production. The satisfaction of human desire through the production of goods is not the end of desire, but the beginning of new desire. For no sooner do we get what we want than we want something else. You buy an automobile. Then you find you need a windshield wiper or something else. And so it goes in human life. There is no limit—there is no end to human desire. Not only that, but our desires are blind. We want what we want—but what do we want? All human desires are, in the first instance, unconscious desires. I remember from my earliest days, a picture which was posted all over the country in England. It was the picture of a very healthy baby in one of those tin bathtubs which you will find nowhere else in the world but England, except it might be in the tomb of an Egyptian mummy. The baby is crying very lustily. Outside of the tub, on the floor, just beyond the baby's reach, is a cake of soap and underneath the picture, the legend reads: "He won't be happy until he gets it." A perfect picture of human life. If that were all the problem, it would be a very simple problem. He won't be happy when he does get it. It isn't what he wants, after all. And isn't it true that so many of the things we desire are not essential to our lives? We become enmeshed with things until there is no escape, and every new thing is a new fetter. I do not wish to say that things are not good, but I do want to say that things are not good in themselves. They are not good except in relation to human personality, and nothing in the world can be good if your personality is not the kind of personality that can give real value to the things of the world.

I think you must recognize that we live in a world of inevitable disappointment. We need to face this fact and have a philosophy of disappointment, and plan how we are going to live in this world rather than in a world of romance. When the first flush of youth is gone, when the happiness of health and energy, when the freedom from responsibility have gone, then you will find that happiness is not given. It has to be achieved through thought and through effort. The problem of living in this world is always the problem of making the best of things; and in making the best of things, you need philosophy, you need will, and you need effort. I would not have you like the foolish generals who have only one line of defence and whose army is routed when the first trench is taken. You need to have spiritual reserves. You need a second line of defence within the soul itself, where none can enter. You will find so many people ruled by unworthy and trivial things. They have no automobile, they have no fur coat, and their friends have. As if it mattered. It only matters when we identify ourselves with an automobile, with a fur coat, and are no more than it. We find so many people living this kind of discontented life. They have placed themselves within the power of fortune and are fearful of every turn of fortune. None of us is worthy to abound until we have suffered loss. We are not worthy to have until we can own without being owned. We are not worthy to possess until we can possess without being slaves. That is the reason for so many of our fears. If we identify ourselves with the things that fortune can give or take away, we

are bound to fear every turn of fortune. So many people are afraid to enjoy happiness for fear they will lose it. We need to have spiritual independence, independence of even life itself. I go so far as to say that we have not entered into the greatest joy of living until we realize that there are many things more worthy than the earthly things, until we see that mere existence is not the greatest of all nor is death the greatest of misfortunes.

Now, I must make some practical suggestions to you for the achievement of spiritual independence. A very great deal depends upon what you expect from life—upon how you interpret success. The first practical suggestion I would make to you is this—that you interpret success in terms of spiritual value rather than in terms of possession. To be successful in life means not so much what we have as what we are. Your success in life will not be determined by the number of things you have. It will be determined by what you are. Isn't that what Jesus meant when he said, "What shall it profit a man if he gain the whole world, and lose his own soul?" If *you* are not something, nothing can make your life a success. I would recommend that you cultivate an appreciation of great things. The greatness of events depends on our own greatness. I quote from Maeterlinck: "Events are like clear water. Seldom have they any form or beauty of their own. They take their form from the vessels we hold out to receive them." And so it is in human life. I feel that nurses and doctors, especially, need to cultivate their appreciation of art and beauty. You are brought so much in contact with the drab things of life, you see so much of tragedy that, for your soul's sake, you must cultivate an appreciation of art. For in art, there is real value for the soul. It is a field into which all can enter for the small price of learning to appreciate it. Don't neglect your soul and your soul's good. There is so much in art that you can appreciate. I could wish for you nothing better than that you take some great artist and make him your own. There is Plato, there is Shakespeare, and innumerable others. I think that you especially need this appreciation of art in your lives.

You are to be congratulated on having a job which will bring you immense satisfaction. You will experience great joy in carrying on your work, in the service of the sick, in knowing that you are needed to relieve human suffering, and could there be anything greater than that? In that, you will find your happiness, and for that, I congratulate you, and in that spirit, I wish you all success. I hope that fortune may be good to you, and so go forth and live your lives with courage, and may God be with you.

The Library Index in Combination with the Journal

THROUGH a combination recently effected between the National Health Library and the *American Journal of Nursing*, it is now possible to secure the *Library Index* and the *Journal* together for $4.40. This is a saving of $1.10 on separate subscriptions to the two. The *Library Index* is issued weekly at the price of $2.50 a year. Order from the *American Journal of Nursing* or from the National Health Library, 370 Seventh Avenue, New York.

Too Many Nurses—Where?

THIS article appears in the March number of the *American Journal of Nursing* which means that it is being written during the last week of January. January, 1929, is not a particularly fortunate date to choose for an article on "Too Many Nurses!" Newpapers are still headlining the numbers of new "flu" and pneumonia cases. Doctors are frantically phoning nurse registries for specials; and hospitals are calling in some nurses from their alumnae whose existence in previous months they had apparently almost forgotten. Public health and hospital staff nurses are off duty by the hundreds, and the depleted staffs are carrying heavily augmented loads. It is no time to talk convincingly about there being too many nurses.

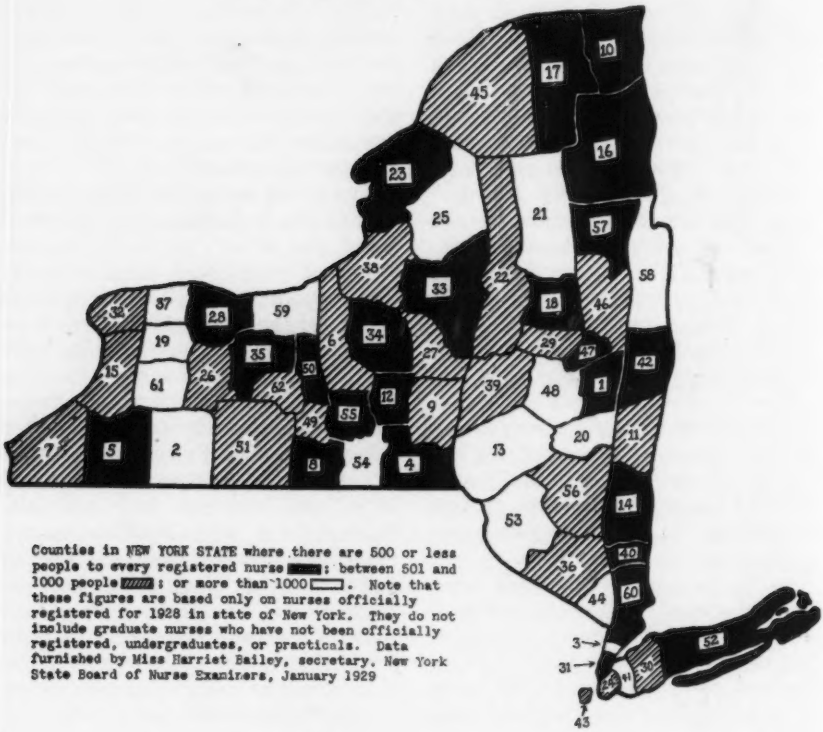
Yet the Grading Committee must not let its own thinking be confused because of a temporary situation. How many nurses were idle last October, and November, and even early December? How many are beginning now, as they read this article in early March, to have long waits between cases? Epidemics solve unemployment problems for the time being because, first, they provide a large additional number of sick patients to be taken care of and, second, they reduce the number of active nurses by putting many nurses on the sick list. But epidemics do not usually last very long, and when they are over the demand for nurses drops. We cannot look to epidemics to solve the employment problem for trained nurses.

There is reason to believe that there are, already, too many nurses. For the United States as a whole, one out of every 590 people is an active graduate nurse who presumably must draw her cases from the other 589 if they become ill; and these figures do not include graduate nurses who have married and left the profession, nor the thousands upon thousands of undergraduates, attendants, and practical nurses who compete with the graduate nurses for cases.

One out of every 590 people in the United States is an active graduate nurse; but what does that mean in terms of your own neighborhood? You cannot tell without a careful study, for the figure given above is an average figure; and averages are built up from all sorts of different conditions. The three maps which accompany this article show some of those differences strikingly.

The maps are for the three states of New York, Louisiana, and California. Each state is divided into counties, which are numbered for identification; and each county is colored to show the number of graduate nurses in that county who are state-registered, in proportion to the county population. If there are so many nurses, or so few people, that one out of every 500 people or less is a state-registered graduate nurse, that county is shown in solid black. If there are between 501 and 1,000 people for each nurse, the county is shaded. If there are more than 1,000 people per nurse, the county is left white; and if there are no nurses at all in that county, it is left white and a ring is drawn around the county number. In looking at the maps you can therefore easily tell that in the white counties there are not nearly enough nurses to care for the population, in the shaded counties there is at least a fair supply, while in the solid black counties nurses are crowded together, probably far in excess of the number which the population of the county really needs.

It is to be remembered in this connection that these figures are based



Counties in NEW YORK STATE where there are 500 or less people to every registered nurse ▭; between 501 and 1000 people ▨; or more than 1000 ▭. Note that these figures are based only on nurses officially registered for 1928 in state of New York. They do not include graduate nurses who have not been officially registered, undergraduates, or practicals. Data furnished by Miss Harriet Bailey, secretary, New York State Board of Nurse Examiners, January 1929

upon the numbers of graduate nurses *registered in that state.* Probably almost everyone familiar with local nursing conditions would agree that in each of these three states—as well as in other states not shown—there are many graduate nurses actually practising but not state-registered. One nurse, unusually well qualified to judge, recently said: "I fear that in New York City alone there are literally several thousand such graduate nurses actively at work, but not registered at Albany." A similar condition is probably true in many other states, and will continue to be true until adequate funds and machinery are available for enforcing the nurse practice acts.

The maps are extraordinarily interesting. If space permitted we should publish under each one a list of the counties, with name, number, principal city, population, number of state registered nurses, and other facts, so that each reader could continue the study for himself. To present all the data which have been gathered for this article, however, would come near to filling the entire magazine, and readers must be content with a rather brief listing of some of the outstanding findings.

People per Nurse

WHAT is the proper proportion of nurses to population? No one knows; and yet we very much need to know. A frequently quoted statement, on which many medical and

public health computations have been made, is that "At any given time, 2 per cent of the population is apt to be ill; and of those who are ill, 10 per cent are ill enough to need hospital care." If these figures represent anything near the truth their implications for nursing are rather startling.

If 2 per cent of the people are ill; and 10 per cent of those who are ill are seriously ill:

State	*Population per Nurse*	*Ill per Nurse*	*Seriously Ill per Nurse*
United States	589 people	12 people	1 patient
California	412 "	8 "	1 "
New York	473 "	9 "	1 "
Louisiana[1]	791 "	16 "	2 patients

[1] Based on white population.

In this table the figures for California, New York, and Louisiana are based on graduate, state-registered nurses only. Were graduate nurses, actively practising but not state-registered, included, the figures in the table above would all be smaller than they are.

If the estimates as to the per cent ill and seriously ill are somewhat near the truth, what do they imply? For the United States as a whole, the table shows 12 ill people for every active graduate nurse; but not all those 12 need nursing. Only one is ill enough to need hospital care. The other 11 probably range all the way from those with mild indigestion, or occasional headaches, up to acutely ill or chronic invalids. How many of those 11, not ill enough to need hospital care, need graduate nurses, or are willing to pay their salaries? As to the twelfth, does he have a special nurse or is he cared for not by graduate nurses but by students?

Some one will say, "But not all these nurses are engaged in bedside care. Those who do other things leave more patients for the bedside nurses." There is truth in that, of course, but the argument works both ways. The hospital superintendent of nurses may do no bedside nursing, yet she and two other graduate nurses may be and frequently are the entire graduate staff for an active 50-bed hospital. Similarly, the public health supervisor may do little bedside nursing, but the staff nurses under her direction may be caring for 10 or 12 patients each. There is little comfort for any one in arguing along these lines.

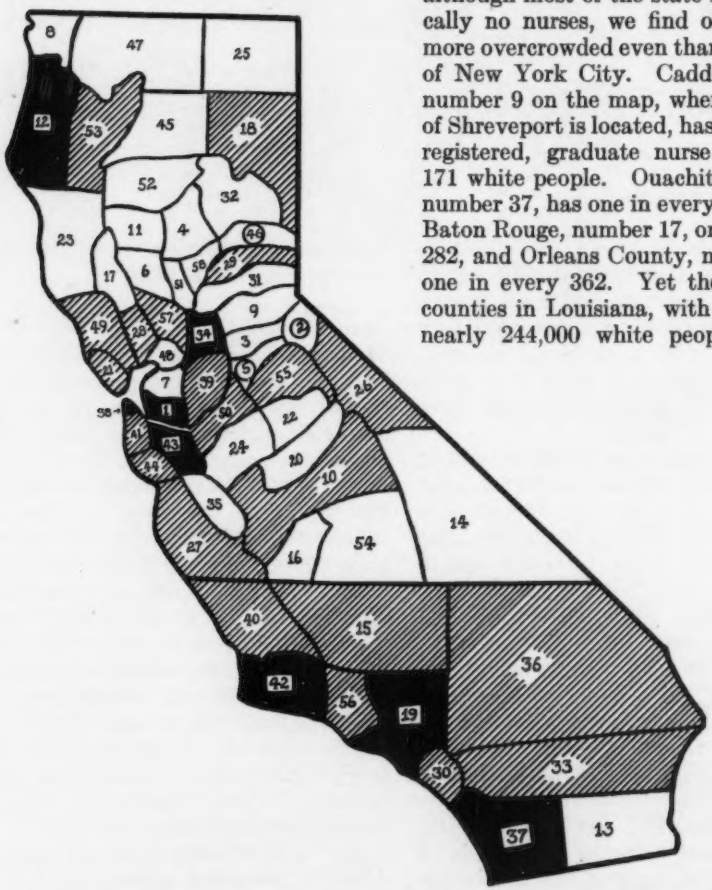
Nurses Flock Together

THE outstanding feature in all three of the maps accompanying this article is the way in which the nurses cluster in certain counties and avoid other counties. In New York State, in New York County, which is number 31 on the map, and lies in Manhattan, the heart of New York City, one out of every 234 people is an active, Albany-registered, graduate nurse; in Albany County, number 1 on the map, the figure is one out of every 394 people; but in Schoharie County, number 48, which is Albany's next-door neighbor, there are only four nurses in the entire county, or one in every 5,391 people. "Why," we ask ourselves, "has Albany so many nurses and Schoharie so few?"

Nor is New York State essentially different from the others. In California, in the County of Santa Barbara, number 42 on the map, one out of every 264 people is a state-registered, graduate nurse; in San Francisco, number 38, one out of 271; and

in Los Angeles, number 19, one out of 294. No wonder California nurses write to headquarters: "Please don't encourage more nurses to come here!" Yet there are three counties in California without even one state-registered nurse.

New York State and California are strikingly alike in their nurse distribution figures. Louisiana presents a different picture, in that so many of its counties are undernursed. In Louisiana, since most of the state-registered graduate nurses are white, and since the white and colored populations present quite different problems, the computations are based on white population only. On that basis, although most of the state has practically no nurses, we find one county more overcrowded even than the heart of New York City. Caddo County, number 9 on the map, where the city of Shreveport is located, has one state-registered, graduate nurse in every 171 white people. Ouachita County, number 37, has one in every 269; East Baton Rouge, number 17, one in every 282, and Orleans County, number 36, one in every 362. Yet there are 26 counties in Louisiana, with a total of nearly 244,000 white people, where



Counties in CALIFORNIA where there are 500 or less people to every registered nurse ■■■; between 501 and 1000 people ▨; or more than 1000 □; Note that these figures are based only on nurses officially registered for 1923 in state of California. They do not include graduate nurses who have not been officially registered, undergraduates or practicals. Counties where circle surrounds the county number do not have a single officially registered nurse

according to the state-registration records there is not a single active graduate nurse.

Families per Nurse

WHEN we say that for the United States as a whole, one out of every 590 people is an active graduate nurse, we are apt to think of the 589 potential patients which the one nurse is to care for, as wage-earners, each of whom presumably can be called on to pay part of the nurse's salary. Yet of course that is not fair, for many of those 589 are children, or housewives, without wages themselves. From the economic viewpoint the picture becomes clearer if we turn our figures not into people per nurse, but families per nurse. The United States Census tells us the typical size of family in every state.

When we begin to think of these figures in terms of average family income, we must ask, How many more graduate nurses can these populations support?

Counties in LOUISIANA where there are 500 or less white people to every registered nurse; between 501 and 1000 white people; or more than 1000. Note that these figures are based only on nurses officially registered for 1928 in state of Louisiana. They do not include graduate nurses who have not been officially registered, undergraduates, or practicals. Counties where a circle surrounds the county number do not have a single officially registered nurse

Which Counties Do They Choose?

WHAT determines whether there will be many or few nurses in a county? One definite factor is the number of people who live there. Nurses go to the thickly populated

Place	Population per Nurse	Average Size of Family	Families per Nurse
United States	589	4.3	137
New York State	473	4.3	110
New York County, number 31	233	4.3	54
California	412	3.8	108
Santa Barbara, number 42	263	3.8	69
Louisiana (white population)	791	4.9	161
Caddo County, number 9	170	4.9	35

counties, and they stay away from the rural counties. The following table shows the average population in each state for black, shaded, and white counties, as shown on the three maps. In the case of New York State these averages omit figures for New York City. The big city consists of five counties: New York, number 31; Richmond, number 43; Kings, number 24; Queens, number 41; and Bronx, number 3, and nurses live in those counties not according to population but according to where the hospitals are located, or the subway lines go. New York City is the exception in the rule that nurses usually want to live in the most populated counties.

Average population in black counties where there are probably too many nurses, shaded counties where there are about enough nurses, and white counties where there are too few:

Counties	Average County Population
New York State (omitting New York City):	
Black—crowded with nurses	116,991
Shaded—well supplied	105,642
White—not enough	34,654
California:	
Black	304,028
Shaded	41,005
White	17,944
Louisiana (white population):	
Black	92,398
Shaded	25,099
White	11,463

These figures show again, what many people have already said, that nurses tend to go to the large cities or thickly populated areas, and to avoid the sparsely settled areas.

What about Doctors?

THE next question is obvious. Are nurses like doctors in choosing where to live? Do they locate for the same reasons? Can you expect that a generous medical supply will mean a generous nursing supply, and vice versa? Some light is thrown on this question by the diagram which accompanies the map for New York State.

This is a "ladder" or "rank" diagram. Down the left hand side run the counties arranged in order, from New York County, which has 8,279 state-registered nurses, down to Hamilton County, which has only two. That is, they are ranked according to the number of R.N.'s, the county with most nurses holds the rank of 1, the next largest the rank of 2, and so on down to Hamilton County which stands 62d, at the bottom of the list.

On the right hand side we again have a list of the same counties, but this time they are ranked in order not according to the number of nurses but according to the number of practising physicians. New York County stands first and Kings County second in the number of doctors, just as they did in the number of nurses, but Westchester County which stood third in the nursing column stands seventh in number of doctors, while Bronx which

Counties in NEW YORK STATE ranked in order, from that having the largest number of state-registered nurses to that having the smallest, together with the corresponding rank for the same county when arranged in order not according to the number of nurses but rather to the number of active doctors.

Counties with their corresponding map numbers	State Reg. nurses	R.N. rank	M.D. rank	Active M.D.'s	County
New York, 31	8,279	1	1	6,068	New York
Kings, 24	2,792	2	2	3,079	Kings
Westchester, 60	1,602	3	3	1,292	Bronx
Erie, 15	1,371	4	4	1,054	Erie
Monroe, 28	1,038	5	5	589	Monroe
Onondaga, 34	658	6	6	557	Queens
Queens, 41	629	7	7	506	Westchester
Oneida, 33	513	8	8	467	Onondaga
Albany, 1	500	9	9	328	Albany
Bronx, 3	411	10	10	254	Oneida
Broome, 4	362	11	11	195	Nassau
Rensselaer, 42	317	12	12	170	Suffolk
Suffolk, 52	307	13	13	159	Rensselaer
Dutchess, 14	284	14	14	159	Broome
Nassau, 30	281	15	15	156	Orange
Schenectady, 47	244	16	16	153	Dutchess
Ontario, 35	226	17	17	148	Richmond
Chautauqua, 7	221	18	18	141	Chautauqua
Orange, 36	216	19	19	140	Schenectady
Chemung, 8	216	20	20	137	Niagara
Jefferson, 23	202	21	21	111	Jefferson
Niagara, 32	192	22	22	103	Steuben
Richmond, 43	190	23	23	96	Ulster
Cattaraugus, 5	150	24	24	95	St. Lawrence
Ulster, 56	129	25	25	91	Franklin
St. Lawrence, 45	126	26	26	86	Chemung
Cayuga, 6	125	27	27	84	Cattaraugus
Steuben, 51	123	28	28	83	Saratoga
Clinton, 10	122	29	29	81	Ontario
Tompkins, 55	116	30	30	78	Oswego
Saratoga, 46	106	31	31	77	Cayuga
Franklin, 17	106	32	32	71	Tompkins
Montgomery, 29	104	33	33	64	Otsego
Seneca, 50	101	34	34	63	Wayne
Herkimer, 22	100	35	35	62	Herkimer
Oswego, 38	100	36	36	62	Warren
Cortland, 12	95	37	37	58	Rockland
Warren, 57	93	38	38	53	Montgomery
Fulton, 18	92	39	39	51	Livingston
Otsego, 39	86	40	40	51	Sullivan
Columbia, 11	73	41	41	47	Madison
Essex, 16	69	42	42	46	Washington
Madison, 27	57	43	43	45	Allegany
Rockland, 44	51	44	44	45	Fulton
Genesee, 19	43	45	45	44	Essex
Livingston, 26	41	46	46	44	Columbia
Washington, 58	40	47	47	43	Chenango
Chenango, 9	36	48	48	43	Genesee
Yates, 62	30	49	49	43	Clinton
Allegany, 2	30	50	50	42	Wyoming
Putnam, 40	28	51	51	40	Tioga
Sullivan, 53	21	52	52	39	Delaware
Wayne, 59	20	53	53	38	Orleans
Delaware, 13	17	54	54	33	Cortland
Wyoming, 61	17	55	55	33	Seneca
Tioga, 54	16	56	56	31	Yates
Greene, 20	16	57	57	28	Greene
Schuyler, 49	14	58	58	26	Schoharie
Lewis, 25	13	59	59	20	Lewis
Orleans, 37	8	60	60	15	Schuyler
Schoharie, 48	4	61	61	14	Putnam
Hamilton, 21	2	62	62	5	Hamilton

is 10th in rank in the nursing column becomes third according to number of doctors.

From the nurse side to the doctor side there are lines to connect the standing of the county on one side with the standing of the same county on the other. If the two sides were just alike (if, that is, the counties with more nurses than others invariably had more doctors than others) these lines would all be level, straight across from one side to the other, like the rungs of a ladder. The more the connecting lines slant up or down, the less close is the relationship.

This type of diagram is a short-cut way of finding out how close the relationship is between the tendencies of nurses and of doctors to settle in certain counties and to avoid certain others. We can see, just by looking at the diagram, that there is, in fact, a very close relationship. It would be perfectly possible to climb that ladder. Some of the rungs are actually level, and most of the others only slant a little, not enough to prevent a foothold. There is in our office a similar ladder diagram for California, which looks enough like it to be its twin brother, but the one for Louisiana is quite different. The Louisiana diagram looks more like a spiderweb than a ladder, and no one could imagine climbing it.

In other words, we know that in New York and California the chances are that where nurses are, doctors will be; and where doctors are, nurses will be. Nurses and doctors like to live in closely populated counties; and are in agreement in their tendency to avoid rural places, but there are very few counties without at least one or two of each. In Louisiana, on the other hand, although doctors are found in every county, there are 26 counties without a single nurse and fourteen others with only one apiece.

What are the reasons? Do the New York and California nurses choose certain counties because there are plenty of doctors there? Do the rural New York and California doctors call upon nurses in their practice more than rural Louisiana doctors, and so make it possible for a few nurses in rural districts to earn a living? Or are nurses and doctors in New York and California, and the nurses in Louisiana attracted to certain localities by other things—good hospital facilities, for example? The figures and diagrams do not tell us. They merely say "Here is some sort of close relationship."

A Few Highbrow Figures

THERE is a mathematical way of measuring that relationship which the statisticians sometimes refer to as the "coefficient of correlation by the rank difference method."[1] This calls for much elaborate arithmetic, but in the end it gives a very simple answer. It tells how closely the two sets of figures agree. If counties with more nurses than others invariably had more doctors than others, there would be 100 per cent positive agreement between the ranked distributions of nurses and of doctors. If counties with more nurses than others invariably had fewer doctors than others, there would be 100 per cent negative agreement between the two. As a matter of fact, when these series of measurements are made, we find

Per cent of positive agreement between ranked county distribution of nurses and of doctors:

New York State	93 per cent
California	94 " "
Louisiana	64 " "

[1] NOTE.—Formula $-R=1-\frac{6\Sigma(R_1-R_2)^2}{N(N^2-1)}R$ not transmuted.

The figures show what the diagrams showed, that for some reason there is a close relationship in New York and California between the distribution of nurses and of doctors, but that in Louisiana the relationship is much less close.

Some Other Reasons

WHY do the nurses go where they go? If we could keep on studying this problem for a few more weeks (it is a fascinating game which we hate not to finish; but there are other tasks ahead of us which call a halt on this) we might be able to furnish many valuable suggestions and perhaps even a few definite answers to that important question. Two special studies have been made for New York State, and we make a guess, which we cannot at the moment prove, that much the same results would be found in California and in many other states as well.

Do nurses tend to go to places where there are ample hospital facilities? The answer is yes, they probably do. When measured mathematically by the same method described in the preceding section, we find an 88 per cent positive agreement between the rank of counties according to the number of nurses, and the rank of counties according to the total daily average of hospital patients in those counties. The figure is very nearly the same when total hospital beds are used instead of average patients.

There is probably a more significant explanation than this, however. Is it merely hospital facilities that nurses seek, or do they rather tend to cluster around their own home schools of nursing after graduation? Here again we cannot definitely prove the point, but we have evidence which strongly suggests that that is the real answer. We do not know where these nurses received their training, but we do definitely know that there is a very close relationship between the number of state-registered, graduate nurses in a county, and the number of student nurses in that county.

While there are exceptions, in general it is true that graduate nurses stay near the schools of nursing, and while we cannot be sure, we suspect it is true that when they can, they stay near their own schools. It is perhaps significant that in New York State the fifteen counties with the fewest graduate nurses have in one case a non-accredited school with seventeen students, in another a school also non-accredited with three students, and the remaining thirteen counties have no schools at all.

When we apply our mathematical formula to these studies we find a positive relationship 94 per cent perfect between counties ranked by numbers of graduate nurses and counties ranked by numbers of student nurses. Our three relationships, for New York State are:

	Perfect Direct Relationship
R.N.'s with average patients...	88 per cent
R.N.'s with M.D.'s.....	93 " "
R.N.'s with student nurses	94 " "

What these figures mean exactly we cannot of course say, but they give good ground for suggesting "Doctors and nurses tend to choose the same sorts of places in which to live." Nurses are apt to live where there are ample hospital facilities, and even more apt to live closely in touch with hospitals which have schools of nursing. It may be that these schools of nursing especially attract their own alumnae. It may also be that hospitals with schools of nursing also are especially attractive to doctors, not probably because of any special siren quality in the student nurses, but rather because, with some exceptions,

those hospitals are apt to be larger and better equipped than hospitals which do not have schools.

How Could Studies Like These Be Used?

IF there are far too many nurses in some places and far too few in others, might it not be possible to persuade some nurses to move, and so go where they are needed? Probably many nurses would be glad to shift their locations provided they knew where to go, and were sure that they would find more, congenial, adequately paid work to do.

If every state nurses' association had a central office with a state secretary, one of her profitable activities might well be to prepare for her own state a map, such as those which accompany this article, and then to make a careful local study of each of the white counties, where there are not enough nurses. Some of these unsupplied counties would not be good locations for private duty nurses because, perhaps, the doctors there are not in the habit of recommending graduate nursing care, so that private duty nurses could not earn enough to live on. In such counties, perhaps the state association might be instrumental in a movement for county public health work, for hospitals staffed by graduate nurses.

In other counties, as yet unsupplied with nurses, it might be found that doctors were eager for high grade, graduate, private duty nurses; and nurses of the right type, if told of the opportunity, might find ample and interesting employment in the new field. A state wide survey to discover where nurses are needed, and reports to nurses in overpopulated counties of attractive opportunities elsewhere might well be one of the important activities for a state secretary.

There are two difficulties in the way of this plan: First, many state nurses' associations do not have secretaries with time or funds to make such surveys. Second, in many states it is impossible to find out how many nurses there are in the state or where they live. Where state registration is required once a year, it acts almost like an official census, and puts into the hands of the nurses facts which are almost essential to the wise conduct of their professional business. In many states, however, nurses need only register once in their lives, and there is no annual follow-up. In such states, the total registration list includes nurses who have died, married, or moved away, in such numbers that for statistical purposes it is practically valueless. In these states, of course, a nurse distribution survey would be, if not impossible, at least time-consuming and expensive.

There are a number of fortunate states, however, where annual nurse registration is compulsory and where full-time state secretaries may find themselves in a position to render vital help to the nursing profession in their own states, as well as to many busy, high grade country doctors, and many hitherto neglected patients, by a study of the distribution of nursing service, and a campaign to help place the right nurse in the spot where she is really needed.

Hidden Sources

BROOKE PETERS CHURCH

IF you met a man in the street who said, "I have the secret of health and happiness!" wouldn't you listen to him, following him through fire and flood to hear what he had to say? And yet, to put such a gospel on paper so that it will reach those for whom it is so vitally important, is hard, for the prescription seems too simple to be efficacious. But I know the secret, for I have tried it, and I have made living an adventure, filling my life with a pageantry which its circumstances did not seem fitted to produce, making each day an excursion into unknown fields. And I should like to share my secret with the profession which seems most closely related to my own—the nursing profession.

For surely the two most closely related women's professions are motherhood and nursing. In many respects the jobs are almost identical. A large part of every young mother's life, unless she belongs to the rich minority, is spent in nursing, and a large part of a nurse's life is mothering in some form, the extent depending on her powers of sympathy and understanding. The difference between them lies in the fact that mothers have nursing thrust upon them,usually with no preparation or training beforehand, and nurses have mothering thrust upon them, usually with no training or preparation outside of the knowledge of medical and physical care. As a mother of growing children who have experimented with most of the known diseases and accidents, I have been forced into practical and psychological nursing fields again and again. The only way to save my health and temper and even sanity, at times, has been to have a secret haven of retreat where I can refresh myself after hours of giving everything in me to my small patients. It has occurred to me that there must be numberless nurses who also need such places of recreation. Mine came to me by chance, and in time took to itself many kindred spirits, until from one hobby, carefully nurtured, I have come to have several which give me untold joy and delight when the end of a day sees me exhausted by the demands of life. For our lives, though varied (too much varied for comfort), are restricted and consistently out-going, which makes for dryness and narrowness and eventually hampers work. No fountain can flow indefinitely without a source of supply, and after a day spent reading aloud, telling stories, answering questions on subjects as closely related as the fourth dimension and the name of Red Riding Hood's wolf, taking temperatures, and talking over symptoms with the doctor, I need mental and spiritual nourishment far more than physical. How much more necessary must it be for the professional nurse, who is not even inspired by bonds of love and relationship to the patient! Realizing that chance threw my hobby in my way, I have wondered if I could not play providence for others, and suggest the means for acquiring what has become such an important part of my life, and what will be mine, I hope, long after my days as nurse and mother are past.

While still at school I was required, in one of my classes, to read a series of essays on the Renaissance. Up to that time, like most of the girls I knew, I had paid very little attention to pictures, and had never seen a great

one. My stock in trade was Maxfield Parrish and Jessie Wilcox Smith, and I rather flattered myself on my discernment in knowing them. So I started to read my book with no premonition of the future, and was surprised to find that I could not understand it. It was written in English, it was beautiful, the words were music, and I wanted to read it, but the key to the meaning lay in pictures of which I knew nothing. Our teacher, seeing the predicament we were in, hung as many photographic reproductions as were available in a study-hall, and day after day, puzzled, eager girls hung about trying to remember which picture was which. The essays grew a little clearer, but I still found gaps. So with care and economy (for my allowance seemed to shrink in proportion to the number of my desires) I chose and ordered all the Perry Pictures[1] which had any bearing on the subject. These I pasted into a loose-leaf notebook, arranged in chronological order, and pored over them by the hour. They were in black and white, and small, but they served their purpose. By the end of the year I was familiar with the outlines, at least, of Italian Renaissance art. Years have passed, I have been abroad, my children are reading my art books now, and the Perry Pictures have been replaced with photographs and colored prints in albums. Little by little a library on the period has grown up in a corner of the bookshelves, to which I add every treasure that is within my means. This year there have been four, all on one phase of the subject—"The Note Books of Leonardo da Vinci," "The Mind of Leonardo da Vinci," both by Edward McCurdy; "Leonardo the Florentine," by Rachel Annand Taylor, "The Romance of Leonardo da Vinci," by Dmitri Mereshkovski, reprinted in the Modern Library at 95 cents. Leonardo lived over four hundred years ago. Why this sudden interest in his genius? Years could be spent in answering this riddle, but I hope from my own reading and thought to show you the key in a short outline of the life and aims of the greatest amateur the world has ever known.

(*To be continued in the April Journal*)

[1] Perry Pictures Co., Malden, Mass., furnish pictures in black and white or sepia. The Art Extension Press, Westport, Conn., has a set of over 200 pictures in color, at a cost of $6.

Infant Mortality in the United States

THE ninth annual report on infant mortality in the cities of the country for the year 1927, published by the American Child Health Association, included the following important data:

The infant death rate for 1927 is given for each of 716 cities of the country. Of this group, 683 cities are within what is called the Birth Registration Area of the country, which includes those states having registration laws satisfactory to the United States Census Bureau, and in which 90 per cent or more of all births are officially registered. The Birth Registration Area, in 1927, consisted of 40 states and the District of Columbia. The infant death rate for this group of cities (683) was 64.9 in 1927. In other words, approximately 65 babies died during their first year of life for each 1,000 born. This is the lowest rate ever attained by the cities of the country as a group. In 1926 the rate was 73.7. In 1915, when the Birth Registration Area was first formed, and consisted of only ten states and the District of Columbia, its rate was 100.

Among the cities over 250,000 population (according to 1920 census) the three with the lowest rates were Seattle, Washington, 41; Portland, Oregon, and Minneapolis, Minnesota, each 47. In the next population group, 100,000-250,000, the four cities with the lowest rates were Bridgeport, Connecticut, 43; St. Paul, Minnesota, 49; Oakland, California, and Grand Rapids, Michigan, each 53.

The Value of Psychiatric Training[1]

A. E. BENNETT, M.D.

THE type of treatment given for any disease has been, throughout the ages, in accordance with the knowledge of the causation of an affliction. Our present concepts of causation of many diseases make more ancient methods seem illogical. Ignorance, superstition, religious belief, etc., have influenced much early medical therapy.

Psychologic medicine is no exception, and is the best example of misunderstanding and ignorance. From medieval times, even up to the nineteenth century, we have been ignorant of all things that pertained to the brain or to mental function. This ignorance has been responsible for very cruel, inhumane treatment of mentally abnormal persons. The Romans were, possibly, an exception, since they treated the insane quite humanely.

During the dark ages religious training and beliefs encouraged ignorance and discouraged scientific investigation. Mental disorders were considered to be manifestations of the flesh or the devil. Persons having delusions and hallucinations gave real proof of demoniac possession. With this popular conception as to the cause, the treatment was to drive out the evil spirits. This concept still exists among certain races; for example, charms certain people wear to keep away certain diseases. Witchcraft sprang from this idea and flourished from the fifteenth century until 1736. During the seventeenth century in England, any one so unfortunate as to have an illness with hallucinations was burned to death. It is estimated that 40,000 witches were burned to death in England alone. This fear of Satan was taught by the church, and influenced public opinion concerning the nature and cause of mental disease until the twentieth century. Even today there lingers a legacy of these dark ages in ignorance and superstition among people whenever "lunatics" or "asylums" are discussed.

When Pinel (1792) attempted his famous reforms of treating the mentally afflicted as sick people, exconvicts armed with whips were in charge of these people, who were kept in chains. The mental disorder of George III (1811–20), brought on by the death of his favorite daughter, started the reform in England. Attendants of the insane then were low-grade persons. A physician who once asked the keeper of the King what happened when the King was troublesome was told: "Sir, we knock his majesty down as flat as a flounder." His majesty spent most of his time in a strait-jacket, had his feet blistered occasionally and received other cruel measures then in vogue, as treatment for an emotional disturbance, the result of a shock over the loss of a loved one!

Up to 1770, in England, insane patients were exhibited in cages for one penny. Attendants with whips stirred them up to show their eccentricities to curiosity seekers. The same curiosity is exhibited today by certain people who visit state hospitals. People ask to see the really bad or violent cases and are surprised to learn that they are being treated as sick individuals, by humane methods, often without any restraint. The idea that there is something horrible

[1] Read before the Public Health Section of the Iowa State Nurses' Association, October 18, 1928.

or mysterious associated with a madhouse, asylum, etc., is far too prevalent.

The Value of Psychiatric Knowledge in Understanding the Patient's Reactions

WHEN we realize that over 50 per cent of patients presenting themselves to physicians as sick show no physical or organic cause for their complaints but instead are suffering from maladjustments to social demands or are medically called psychoneurotic, one realizes the necessity for more adequately preparing the nurse to help in their care.

As the general practitioner is learning more and more of the cause and effect of abnormal psychologic reactions upon the individual's health, so in turn he will turn more to the nurse who has a knowledge of mental aberrations. The nurse of the future will of necessity have to be psychiatrically trained. She will no longer be successful in treating the physical side alone.

Psychiatric training does not mean that the nurse needs to treat mental cases, but it prepares her to recognize the mental aspects of physical illness. Many physicians fail to recognize in their patients the large influence of abnormal emotional reactions producing functional symptoms. I have had many instances of nurses gaining psychiatric experience through suffering from a nervous collapse themselves. This has benefited them, but I felt that had they had psychologic insight before, the mental suffering they endured could have been prevented.

Psychiatric training teaches the nurse the meaning of treating social maladjustment. The patient's nervousness or abnormal behavior is his reaction to his maladjustment. The heart, stomach, or head symptoms are merely external functional signs of the inner inadequate self-expression or social maladjustment. Study of mental reactions makes the nurse appreciate the powerful influence of emotions upon the physical economy through upset of the autonomic nervous system.

A nurse who has had psychiatric experience is a better nurse, she makes easier and better contacts. Through understanding the mental aspects of a case, she is generally more observing. As Dr. Ruggles states it: "Every nurse who has a training that includes an understanding of the mental factors entering into human adjustment will be better able to be the ruler of her own destiny and will be qualified to meet the disorders of the central nervous system that are so often met in acute and chronic illness."

A nurse should learn the symptoms of various mental abnormalities and especially the methods of modern treatment. After obtaining this knowledge, she finds that patients are not queer, funny, lunatics, or "nuts," but human beings just like herself who have deviated to one extreme or the other from normal reaction. With this understanding she can aid recovery. She can understand the patient's reaction in comparison to her own reactions, and the reason for the oddities or peculiarities becomes clear.

With psychiatric training the nurse tends to control her own emotional reactions, she does not betray her worries or lose confidence. She learns not to be worn out by the eccentricities of the patient. She finds she must have good emotional control herself in order to gain the patient's confidence; above all she learns she must not lie or deceive the nervous patient.

Value of Psychiatric Training to General Nursing

1. Psychiatric training teaches the nurse how to observe the patient's reactions and how to record psychologic reactions of the patient. Special training is necessary in order to acquire this ability of evaluating and charting intelligently odd behavior so that the mental aspects receive consideration.

2. A nurse who has had psychiatric training appreciates the value of occupational therapy, she learns ways to provide recreation for the patient and the necessity of stimulating interests in a self-centered individual. Occupational therapy has never received proper recognition as a valuable therapeutic aid in shortening any chronic illness.

3. Psychiatric training teaches one the value of hydrotherapy, particularly the value of continuous baths in relieving nervous tension or excitement.

4. Through such training, a nurse learns how properly to manage and control an irresponsible patient.

5. Mental nursing teaches the nurse to remove prejudice toward the mentally ill, it teaches the nurse that all patients are mentally ill to a degree.

6. Lastly, neuropsychiatric experience develops self-patience, control, precise thinking, tact, firmness with human kindliness. With this equipment, a nurse is capable of helping the cranky or neurotic individual. If the nurse does not understand these people, the strain upon her own sympathies and patience is too great. A well trained psychiatric nurse acquires the habit of meeting abnormal psychologic reactions without self-wear and tear and without friction with the patient.

The Value of Mental Hygiene to the Public Health Nurse[1]

THE great field of preventive nursing in mental hygiene has gone thus far largely to social service although to my mind much of this great field belongs to the public health nurse. The reason for this has been, of course, that social workers are receiving special psychiatric training and the public health nurse has not had the necessary training in problems of mental hygiene to make her an efficient agent in handling public health social problems. The public health nurse can never properly enter this great field without taking the right kind of postgraduate, psychiatric training.

We need more nurses to continue and further the aims of mental hygiene, which means the working out of causes and prevention of delinquency, crime, mental disease and all social maladjustments. How a school nurse, for instance, can be successful without psychiatric training that includes extensive study in behavior problems of children, is beyond my comprehension. She is constantly in touch with the nervous child showing behavior oddities or unable to progress in school, etc. These are factors that produce social or economic misfits. Early tendencies in children, when understood, are readily corrected. A study of personality problems, habit-training, etc., must be considered in the school problem as well as physical defects. With psychiatric training the nurse will emphasize the importance of considering proper habit-training, self-control, the study of the type of associates, spoiled-child reactions, day-dreaming, shut-in tendencies, etc.

The public health nurse by having a psychiatric point of view when visiting families can often render great service, and can make many difficult problems easier. By early recognition of abnormal trends in the family life she may secure aid that will prevent a serious mental breakdown in an adult or give advice that may help mould a strong personality in a child rather than a character that will succumb to mental stress later on.

Public health nursing should play an important part in the follow-up of

[1] Attention is called to the Mental Hygiene number of the *Public Health Nurse*, October, 1928.—ED.

patients discharged from mental hospitals. With psychiatric insight, she may be able to prevent recurrences of mental illness.

The Future Needs in Psychiatry of the Nursing Profession

NURSES have avoided psychiatric training for several reasons, some of which I have emphasized, such as the misconceptions of mental disease, stigma of disgrace attached to mental illness, etc. Many nurses look upon the duties as simple custodial care, when as a matter of fact proper mental nursing requires the greatest of skill. Any nurse who can successfully cope with an acute psychosis can handle any nursing problem.

If psychiatric training became a general requirement in nursing training, I am sure the study would interest every nurse, particularly if the courses were given in a practical way with clinical case examples.

What will the future hold for psychiatry? Medical schools generally are recognizing the importance of devoting more time in the curriculum to the study of mental diseases. Such schools as Harvard and Johns Hopkins are giving more hours of instruction in psychiatry. Many hospitals are offering special training for nurses. The morbid sentimentality concerning mental illness and mental hospitals is passing. The old asylum will soon be gone. What are we going to do to meet the needs of the increasing numbers of mental cases? The magnitude of the problem of mental disease is already more than insane hospitals can cope with. About all the state hospitals can take care of is the large group of chronic or incurable cases. The crying need throughout the country is to provide adequate care for early potential mental conditions.

General hospitals will have to solve this problem; it is the duty of general hospitals no longer to neglect mental illness. General hospitals, even in rural communities, provide adequately for the care of all physical disorders. Practically no provision is made for the care of nervous illness. A goodly number of patients suffering from nervous disabilities recover with early treatment, and a failure to obtain this treatment leads to chronicity or incurability. Every general hospital is constantly harboring mental cases unknowingly. But the large group of borderline cases, social, economic or domestic maladjustments are not being cared for properly. Either they are running to cultists or are laboring under the false belief of an organic disease not diagnosed by physicians. Many are drifting until their oddity becomes exaggerated enough so that they are committed to state hospitals. Organic mental disease—deliria, medical, postoperative or obstetrical—occur constantly in general hospitals which are not equipped to give them proper care.

The badly understood, mishandled group of psychoneurotics with physical complaints becomes a vexatious problem for the practitioner and nurse in a general hospital. They become dissatisfied and blame the hospitals or doctors. This group alone justifies the demand for adequate psychiatric departments for these cases. If 5 per cent of the hospital beds in city hospitals were set aside for a psychopathic department with hydrotherapy, occupational therapy and competent nursing, these people could be scientifically cared for and the majority readjusted or cured.

A few soundproof rooms are readily obtained for more disturbed patients and prevent noisy patients from upsetting others on the same floor.

At the University Hospital in Omaha, we have psychopathic wards in the same wing of the building with surgical and medical wards. The psychotic patients do not disturb other patients in the least. Soundproof rooms for the active patients prevent other patients even on the same ward from being disturbed. Such an arrangement is perfectly practical in any hospital.

Until hospital authorities recognize the need and prepare future institutions to meet the need, medical science cannot hope to discharge its full duty in the care of the sick.

In closing, I hope I may have given something to interest the nurse in learning more of the misunderstood nervous patient. I also hope I have enlisted your aid in correcting erroneous conceptions of mental disease, and that your moral support will be given in influencing hospitals to meet the urgent need for better care of mental illness. It would please me if more of you decided to interest yourselves in the actual care of mental patients and learn the reward of mental nursing in seeing reason restored to the mentally ill. Mental hygiene has made great progress in the past one hundred years. It is beyond my imagination to picture the progress that will be made in the next century. This can be hastened greatly if the nursing profession assumes its share of the responsibility.

Operating-Room Technic

The Value of the Use of Illustrations in Teaching

MARGARET WELLMAN HUGGINS, R.N.

THE acquisition of a greater knowledge of the psychological principles involved in the learning process has profoundly affected methods of teaching during the past decade or so. The real value of the association method of teaching, as opposed to the old method of learning by rote, is just beginning to be fully appreciated and its possibilities realized. The use of illustrations constitutes one of the principal technics of the association method, and the school systems of this country are more and more adopting as far as possible "picturized" information as an aid in classroom teaching.

The instructor of operating-room technic at the University of Michigan Hospital, encountering much difficulty in imparting a certain type of information to student nurses, saw in the association method of teaching, particularly the use of illustrative material, a possible solution for many of her teaching problems. She, therefore, made every effort to accumulate the greatest possible amount of illustrative material relating to operating-room procedures with the idea of experimenting with illustration in the teaching of operating-room technic.

A chart was made of the dissecting kit, gastro-intestinal instruments, gynecological instruments, etc., by mounting the pictures of instruments cut from catalogues. These pictures were mounted on heavy cardboard. Below each picture was pasted the printed name of the instrument. On the backs of the charts were listed the names of the instruments and their

prices. The price of each instrument was given, as it was felt that it would bring to the student much greater appreciation of their value. The charts not only gave the student a visual picture of the individual instrument, but also gave her a mental picture of an associated group of instruments. In this way the teaching of the instrument kits was made easier and quicker. The charts were photographed and reduced to one size which facilitated their handling.

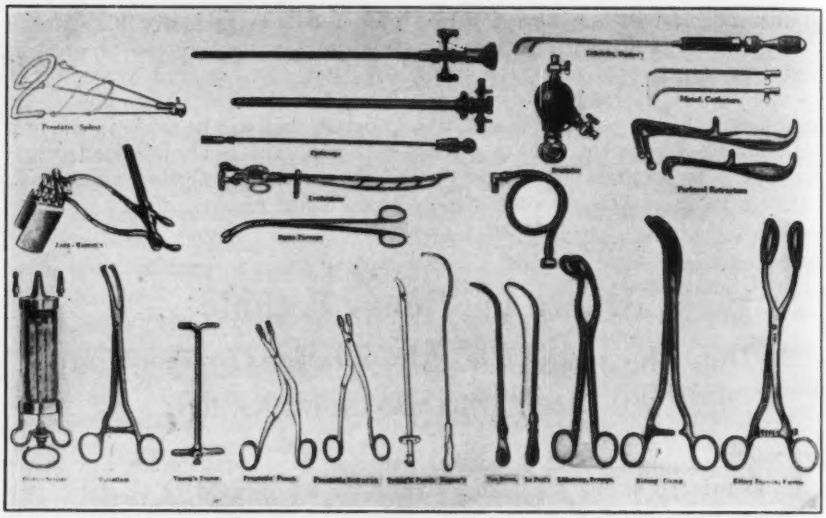


FIGURE 1. METHOD OF ILLUSTRATING UROLOGICAL INSTRUMENTS IN SURGICAL TECHNIC COURSE FOR NURSES

A similar chart was made of the various types of sterilizers, namely, the bean-boiler; sterilizers for boiling instruments heated by steam, gas, and electricity; an autoclave of the instrument variety and one of the large linen or dressing autoclave. Each chart gave the various ways of obtaining moist thermal sterilization. Pictures of sterilizers were procured from instrument or hospital-supply catalogues, or directly from the manufacturers. Blue prints gave the construction of the sterilizer in detail and printed directions (which usually accompanied the blue print) gave explicit information as to how to operate and take care of the sterilizer.

Manufacturers of catgut publish well-illustrated pamphlets showing the steps in the manufacture of catgut. These pamphlets describe in detail the manufacture of catgut; each step in preparing finished gut from the crude article is fully illustrated, as well as described. Such descriptions and illustrations will, without question, forever lay the ghost of the famous answer found in all too many examination papers—"Catgut is made from the intestines of the cat."

In no phase of the course in operating-room technic is the power of imagination more necessary and are illustrations found to be more valuable than in the teaching of operations. Even though the instructor takes infinite pains to describe carefully and in detail an operation, the student

nurse very frequently receives a blurred and confused picture of the procedure. If the instructor can show the student a picture of the operation, this enables her to see what has been done, and to visualize the field of operation in relation to the surrounding structure. To meet this need, a series of pictures showing the more common operations was collected. There has been a splendid series of plates of standard operations, advertising catgut, appearing in the medical journals during the past year. The instructor in charge of the course secured these (these, too, were secured without cost) and then to add to her material, she went through the reprints of articles written by the staff surgeons for various medical magazines and secured from them many valuable plates. These illustrations not only made each operation clearer to the student, but stimulated, likewise, closer observation of the operation while it was being performed and made possible a more intelligent interpretation of operative technic. It was felt that if the student really comprehended what was done at the operation, she would have a clearer understanding of surgical principles; for example, it was believed that if the student really comprehended an arthrodesis of the knee she would readily see that it is a treatment of tuberculosis of the joint as it gives the joint rest.

The mechanics of a gastro-enterostomy are apt to be very puzzling to the student nurse, even though she might understand from the word "gastro-enterostomy" that an opening is made from the stomach into the intestine. With this problem in mind the instructor, with the assistance of one of the doctors, made a life-size stomach, duodenum, and jejunum out of rubber dam. A Dakin's tube was introduced into the duodenum to illustrate the common bile duct. The jejunum was tacked in place for a posterior gastroenterostomy, and the stomach and jejunum were stuffed with cotton, leaving the duodenum limp. With this inexpensive and home-made model, can be demonstrated the passage of food from the stomach into the jejunum and the flow of bile into the duodenum, which otherwise lies idle.

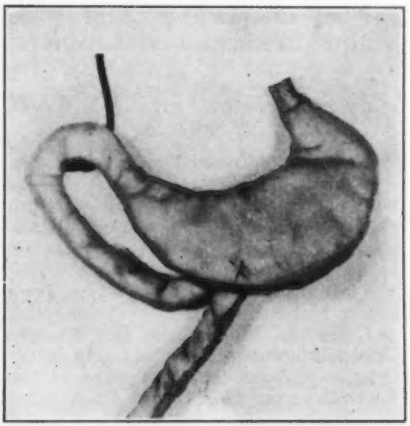


FIGURE 2. MODEL ILLUSTRATING GASTRO-ENTEROSTOMY

The charts and plates were all carefully mounted on black paper and placed in a loose-leaf notebook, each chart and plate being placed opposite the lesson in operating-room technic which they illustrated. Thus the illustrative material was easily accessible, ever ready for use and properly protected. It seems well to note at this point that the sterilizer chart and illustrations of the manufacturing of catgut are used for the introductory lessons, while the dissecting set, gastro-intestinal instruments and the operative plates are used for the lectures on general surgery.

It was felt that the use of such materials as have been mentioned is

simply invaluable for giving the student nurse a sound background in operating-room technic. None of the materials cost much money—in fact, most of them cost nothing, as the manufacturers are only too glad to send information on their products, as they see distinct advertising value in such distribution of their pamphlets, blue prints, etc. We, at the University of Michigan Hospital, are strong advocates for visual education, and we are planning to use "picturized" information more and more.

Commonwealth Fund Aids Rural Hospitals

MODERN fifty-bed hospitals have been awarded to five communities since the beginning of the Fund's rural hospital program, for which $358,438 was appropriated during the year. The first of these was opened in Farmville, Va., in November, 1927. The institutions in Glasgow, Ky., and Farmington, Maine, will be completed this spring, and those in Beloit, Kans., and Wauseon, Ohio, will probably be opened before the end of 1929. "The rural hospital program," says the tenth annual report of the Fund, "is an experiment in social organization involving much more than a building project; it is an effort to attack from a fresh angle the difficult problem of medical and public health service in small towns and the open country, and to change community standards in respect to the care of the sick, the prevention of disease and the protection of health." Typical of the general program is the work now going on in the district of nine Virginia counties served by the Farmville Hospital. The State Health Department has organized this territory into a single unit with a district health officer, under whose leadership a comprehensive health service is being gradually developed. Two medical institutes have been held, with clinical demonstrations and lectures on chosen topics. Ten local physicians have been awarded fellowships for brief postgraduate courses at well known medical centers. The hospital itself is proving its usefulness to the community and has been operated under the direction of the local Board of Trustees on a gratifyingly high standard. As with all hospitals constructed under the Fund's cooperative program, a third of the cost of the building and equipment and the entire expense of administration have been assumed by the local community.

Trench Mouth or Vincent's Infection

VINCENT'S infection, or "Trench Mouth," was first noticed about 1897, and has undoubtedly been more or less endemic since that time. It was not until the World War, however, that the disease took on epidemic form. . . . Since the World War it has seemed to spread slowly through the states, or perhaps it has been more promptly recognized.

Vincent's infection may present itself in the mouth or, as Vincent's angina, in the throat, or the two may be present together. It is believed to be due to the combined action of two varieties of the same germ. Inflammation and the formation of ulcerative areas of greater or less magnitude, located on the mucous membrane of the gums, cheeks, tongue, and tonsils are characteristic of the disease. The milder or more common form is slower in its progress and remains on the surface, not affecting the membrane deeply. . . .

The infection is carried and spread from an infected individual to a well one by direct contact. Eating utensils not properly cleaned, face towels, drinking cups, personal articles, kissing, and living in crowded buildings without plenty of fresh air and sunshine are some of the causes. The exact mode of transmission has not been entirely agreed upon by all authorities.

To prevent the likelihood of infection, everyone should keep his mouth in a clean, healthy condition. When teeth first begin to decay, they should receive immediate attention, and the small cavities should be filled without delay. No decayed teeth or broken-down roots should be allowed to remain in the mouth. The mouth should be thoroughly cleaned by the use of a toothbrush and dental paste or powder, or even soap or salt and water, after each meal, if possible; but in any case always before retiring for the night, and the first thing on arising in the morning.—From *Health News*, U. S. Public Health Service.

Editorials

The A. N. A. Cares

TO the nurse who has not yet "discovered" the A. N. A., the nurse who belongs only because it is the thing to do, or who perhaps does not belong at all, the A. N. A. seems a remote and rather soulless machine. But ask those who have recognized it as the source of professional stimulation or of assistance in time of prolonged illness and have thus made intelligent use of their membership, and it is revealed to be an intensely human thing.

Take the January Board meetings, for example. Concern for nurses, individual nurses giving nursing service to individual patients, and for individual nurses no longer able to give such service, dominated the thought of the members of the Board and colored many of their actions. Some of these were specific. For example, one expression of the concern of the Board for the welfare of individual members was the plan for a study of registries. Another was the extremely careful thought given to aiding the Harmon Association to develop an annuity plan which could be offered the nurses of the country with the complete approval of the Board, as is done in this issue on page 275. A third was the reorganization of the plan for administering the Relief Fund and the consolidation of the various committees having to do with insurance, annuities and relief.

The reports we publish are brief and to the point. Back of each one is a record of much thoughtful and devoted effort by members of the committee, nurses who have given freely of their off-duty time and of their best thought to further the interests of the thousands of members they represent. Back of it all lies the appreciation of these women, chosen by the profession to represent it, of the tremendous collective contribution to the welfare of the world of individual nurses, faithfully and patiently working over their patients. Many a nurse is unable adequately to express her own needs, hopes, longings, or even her despair when economic disaster strikes. The members of the Board and the nurses at Headquarters have done their utmost to interpret these things in a friendly, helpful fashion. The members of the A. N. A. have increasing cause to be grateful to a Board which is discerning, forceful and courageous.

That the A. N. A. should be looked upon by all nurses as the highest expression of national and professional solidarity was emphasized over and over in joint board meetings and at other conferences. Membership in the A. N. A. has always been a prerequisite for membership in the National League of Nursing Education. The Board of the National Organization for Public Health Nursing has now approved of making it a requirement for its professional, that is, its nurse members, and has referred the matter to its revision committee for action. In this way the collective power of the profession may be the

concentrated on important objectives through the American Nurses' Association.

Financing Grading

WHEN the work of the Committee on Grading Schools of Nursing was undertaken, it was estimated that the five-year program of study would necessitate a budget of $200,000. If every registered nurse in the country had contributed one dollar, the amount would have been raised and the matter of financing would have been a settled issue. Of course that didn't happen. Some wit has said that the only example of perfect co-operation ever recorded occurred when Noah sent out his call and "*all* the animals came!"

As a matter of fact the financing of Grading was not begun on that basis. The Committee has, for parents, seven national organizations, and the financing was begun on the assumption that annual contributions from the parent organizations, and the realization of lively expectations of gifts from Foundations and individual philanthropists, would carry it. Two of the Foundations, the Rockefeller and the Commonwealth, are helping. Actually, the very first work was done with the nucleus of $15,000 contributed by Mrs. Chester Bolton of Cleveland.

Of the National organizations participating, the nursing organizations alone are accepting full and continued financial responsibility for the study. It is a cause of amazement and congratulation on the part of the educational members of the committee that this is so, but it is not a cause of amazement, although one of self-congratulation, among nurses. Nurses are a highly self-respecting and self-reliant group. They really started the Grading studies, although the other organizations did give financial aid and continue to give, through their representatives, valuable assistance. What nurses start they see through, as has been proven more than once.

On page 347 may be found the quotas assigned the various states. These are based on A. N. A. membership. Many state associations have expressed appreciation of the quota plan. A quota gives a definite objective and is also a thoroughly fair basis both for computation and for effort. The sum needed, over and above amounts already paid or pledged is about $40,000. When it is remembered that the membership of the A. N. A. is now over 70,000, the task becomes relatively a simple one. It will be interesting to watch the individual states get under way and to note the quick returns from some of them.

It is heartening to report that Mrs. Bolton has expressed her continued interest by a recent gift of another $15,000. This does not alter the quotas because they were made up after the gift had been received. This is more than a gift of money. It is an expression of faith in nurses and in the work of the Committee that has value far in excess of the actual dollars, for it comes from one of the most profound students of nurses and of nursing to be found in the group we call "lay." The faith of such as these must be and shall be maintained. We have faith to believe that the quotas will be raised, the work of the committee will go on and at the end of the five-year period the profession will have found a way to carry on whatever system of grading shall have been found to be desirable.

Registries

AS announced last month, one of the first actions taken by the Board of Directors of the A. N. A. in the

January meeting, was to endorse a plan for a comprehensive study of registries. This is a matter of very great moment. Strenuous efforts have been made in a number of places to bring the service of central registries, service to nurses and service to patients, to a high state of efficiency. If, through study, the best elements of each can be presented to all the interested groups, together with a comprehensive analysis of the difficulties encountered in developing a high type service, followed by a clear-cut statement of objectives, there is real hope of rapid progress.

Julia P. Wilkinson, a graduate of Wellesley College and of the Massachusetts General School of Nursing, has been chosen to make the survey. Miss Wilkinson has had broad experience in public health and social service work. She has worked abroad and at home, in cities and in rural areas. Recently she has done private duty nursing. With such a background, Miss Wilkinson cannot fail to make a study that will be far reaching in its results. Back in 1909, Miss Palmer said editorially:

> We seem to see in the dim future a network of central registries through all the states, one central headquarters established by each state association and under its direction and supervision, with a ramification of county registries, reaching out to all the larger centers, each to cover a prescribed territory with an interchange of information and credentials.

After twenty years what was to Miss Palmer a dim future is a vivid present to us. Shall we highly resolve to bring her prophecy to pass?

Interesting Lay People

IT is a generally accepted fact that there are more lay people intelligently interested in public health nursing than in any of the other branches of nursing. This is natural, since the National Organization for Public Health Nursing has always had lay members and the interest of these members is by no means a merely sentimental one. At the recent Board meeting it was reported that, since the Institute for Board Members held in New Haven and the formation of a section for Board Members, there have been many demands for help from this group for all parts of the country. These leaders are entirely frank about their ignorance of the technic and of many of the traditions of nursing. Their great value lies in this frank acceptance of their limitations and their eagerness to secure sound information on those things with which members of public health nursing organization boards may rightfully and profitably concern themselves.

There is an interest in nursing of another sort, springing up among other women members of the Federation of Women's Clubs. This interest is more diffuse than that of N. O. P. H. N.'s lay members but, state by state, the development goes on. For example, it was a Red Letter Day when the President of the New Jersey Federation, with the Executive Secretary of the State Nurses' Association, visited National Nursing Headquarters for the purpose of "finding out about grading nursing schools." When a keen intelligence and a sympathetic mind are applied to such a problem, things begin to happen! The first fruits appeared in the *New Jersey Clubwoman*, in the form of a review of "Nurses, Patients and Pocketbooks." Knowing something of the happy relationship existing between the State Nurses' Association and the Federation in New Jersey, it is safe to predict that even more constructive effort and assistance for the New Jersey nurses will be accorded than in the past.

When the Maryland nurses met in annual convention in February, they were delighted to find that the *Maryland Clubwoman* had devoted space to a very attractive presentation of their program, with pictures of most of the superintendents of nurses, and that further space was given to a concise discussion of nursing participation in the work of the State Department of Health. Here again is the seed of constructive and coöperative effort. Nurses were urged by one of their own number to subscribe for the magazine, thus proving that coöperation really means a movement from two directions toward a central goal.

Other state nurses' associations are members of the state Federations. The affiliation is valuable only when it is genuinely coöperative, each group giving and receiving stimulation through friendly contact and coöperative effort with the other. Nursing is, in essence, women's work. Now that we have a volume like "Nurses, Patients and Pocketbooks" ready to our hands there is no reason why we should allow the thousands of club women and the hundreds of women serving on hospital boards and committees to remain in ignorance of our professional aspirations, achievements and problems, as we have tended to do in the past. When well informed, they have great collective power when legislative affairs are in progress and many of the individual members are in a position to aid local progress in nursing education. It is well to remember that, in our modern civilization, no group can live by itself alone.

The Bordeaux School Fund

THE state associations are actively at work raising their quotas for the completion of the American Nurses' Memorial to their comrades who died in the World War. That memorial is the Nightingale School for Nurses, at Bordeaux, France.

The Board of Directors of the Monmouth County Social Service Association (New Jersey), has a unique plan. Evelyn S. Walker, Director of Public Health of the Association, writes that the Board has offered Dr. Anna Hamilton of the Bordeaux School a six months' scholarship in Public Health in America. Three months of the time are to be spent in Monmouth County and a special schedule for the other three months is to be arranged by the Committee.

Miss Walker did some extraordinarily brilliant public health work in the devastated areas of France in the post-war days, and is therefore well qualified to map out a thoroughly valuable program for the nurse granted the scholarship. As the amount is a most generous one, covering all expenses from the time the nurse leaves France until her return, it is stipulated that the person chosen must be genuinely interested in public health nursing, and also that, unless Dr. Hamilton herself is to be a delegate to the International Council of Nurses in Montreal, the nurse shall be a delegate from the school and empowered to receive the gift of the American nurses for the completion of the Memorial.

With such a delightful plan under way, encouraging the Bordeaux School to send a delegate to Montreal to accept our gift, it is important that the American Nurses' Association Committee be enabled to complete the collection of the necessary funds at an early date.

Eminent Teachers

Maud C. Kelley, B.S., R.N.

(A tribute from one of her students)

THE teaching ability which Miss Kelley has demonstrated for many years as Supervisor of the Pediatric Department and Instructor of Pediatric Nursing in Bellevue School of Nursing may have begun with her graduation from Albany State Normal College and her teaching of primary grade students for six years. She entered Bellevue School of Nursing in 1910 and after graduation returned to her home in Skaneateles, New York, to care for her father. During this period she did some active work with Campfire Girls. Some four years later she returned to Bellevue as a charge nurse on a medical ward and remained there about two years when she left to go overseas with the Bellevue Unit, in 1918.

MAUD C. KELLEY, B.S., R.N.

On return, her work started on the Pediatric Service as a head nurse on a children's convalescent and chronic ward. Here she remained for nearly two years when a Teaching Supervisor was deemed necessary. She was recommended and chosen. Her teaching and work with children make us realize her interest in them, and her desire to help them is further shown by her never-tiring efforts of almost ten years. She has been heard to say: "My interest lies wholly with the children and their care and in order to give them good care we must educate our nurses."

It was at this time that the teaching program was introduced and its foundation built. The service was not well organized and heretofore no real attempts at ward teaching had been made. In the beginning, ward equipment and its arrangement were standardized, as far as possible, on pediatric wards.

An improved method for assignment of students to wards was marked out whereby nurses were put on the convalescent wards before acute wards. This was done to familiarize them with the service and with the care of

children before having to care for an acutely-ill child.

Undaunted by the lack of a suitable classroom, Miss Kelley gave the first nursing classes in the bathroom, off one of the wards, with nurses standing about the tub. Naturally, this was very tiring and the space inadequate. With characteristic determination, she set out to get a classroom. At first it was in connection with another department but soon it was used for pediatrics only.

More nurses were essential to give good nursing care. In order to get them, a real teaching program was necessary. This rested in part upon convincing doctors of the advisability of teaching nurses, and the outcome was their coöperation in giving lectures and clinics.

Bedside clinics were started and given by the resident physician on the service. Then rounds were made on the wards and important cases discussed. Interest and attendance increased until there were too many to make rounds and clinics were given in the classroom.

A library in the classroom for pediatric reference reading was started with five of Miss Kelley's own volumes. Today there are about seventy-five volumes.

The first nursing classes were made up of important demonstrations and the underlying principles connected with them. Today these classes are used to review, quiz and drill, with some few demonstrations. Most of the demonstrations are given, however, in the classroom or on the ward while students are on the service. Miss Kelley's enthusiastic and persistent efforts for the department and the teaching program have helped to bring about many improvements.

Her success as a teacher of pediatrics is built upon two predominating characteristics—her love of children and her sympathetic understanding of student nurses. She is a rare idealist who has method and a patient determination to achieve her ideals. With a quiet, reserved manner she sets a high standard of excellence in nursing which is a lasting stimulus to her students and other associates.

Being no less a student than a teacher, she has always made close contact with educational advances in nursing. The strenuous demands of the department left energy enough for courses at Teachers College during those busy years. Even now, we find her doing graduate work at Columbia.

"And I say that life is indeed darkness save where there is urge,
And all urge is blind save when there is knowledge,
And all knowledge is vain save where there is work,
And all work is empty save when there is love;

And when you work with love you bind yourself to yourself, and to one another, and to God."

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY LAURA R. LOGAN, R.N.

Coöperation in Education[1]

EDITH FOSTER FLINT, PH.B.

WHEN Havelock Ellis was a very young man he went to Australia for his health and spent two or three years teaching in the Australian bush. In his "Dance of Life" he records the fact that he had great pleasure out of the notes that he received from parents of his pupils, who, he says, "never having been taught to spell were able to spell in the grand manner." Would that my ignorance of nursing education might enable me to speak to you "in the grand manner." I can but lay before you some proposed principles founded on my experience, trusting that you who are informed will make the application, the synthesis, if, as I hope, the principles have soundness and worth.

The great social movement of the last century has been toward democracy. In politics it is a truism that a democracy, to succeed, must be built on a foundation of knowledge, on an educated electorate. The American system of public education from kindergarten to state university is built on that theory. However short it falls of its aim, however fouled it has been by corrupt politics, that is its foundation. And as education has developed it has become progressively more democratic, or perhaps better, more coöperative. This is not to say that there has not been democratic education in the past. Mediaeval universities like those of Bologna or of Paris arose where they did because of collections of important manuscripts at those places. The students hired their professors; in fact they could both hire and fire. That is, if they did not like what a professor was giving them they could threaten to go away, removing therefore from the professors and from Paris or Bologna the revenues they brought. But so long as they stayed by their teachers they listened rather than participated.

My position and aim in this brief talk originate in two things: the conviction that there has been too much "spoon feeding" in education today, and the report that in this respect nursing education tends to err more even than academic education. Let us ask ourselves therefore the question, Cannot the procedure in schools of nursing education be liberalized, democratized?

At once the great difference between the professional education of a nurse and academic education must be considered. On the training of a nurse will depend sometimes issues of life and death; the inaccuracies in the mind of a young woman who is going to lead a purely social life, or even of one who is to teach English or history, will be unfortunate, not tragic or

[1] Read at the annual meeting of the Illinois League of Nursing Education, held in Joliet, October 19, 1928.

appalling. Realized too is the great part that drill must play in the training of a nurse. But is it not true that, just as we learn to do by doing, so do we learn to think by thinking? All drill and no discussion makes Jill a dull girl—a mere routine worker unable to solve a new problem.

My primary contention is that there should be more student and less instructor in the educational process or, better, that the instructor should be less vocal. We do not respect our students enough. Even a child responds to treatment as an equal. I am remembering a recent picture in *Punch*, where a new nurse-maid endeavoring to ingratiate herself with her small charge says, pointing to a pair of dogs in the park: "See the nice bow-wow." And the child, with an expression of cynical weariness inquires: "Do you mean the Cairn or the Sealyham?" The nurse's mistaken condescension is not rare on the platforms of classrooms. Dean Pound of the Harvard Law School, a scholar who regards the law as a constructive social expression, not as a mere dry bundle of precedents, once said he had long known that he must take for granted the presence in every group that he taught of at least one mind superior as an instrument to his own. This must be true in every teaching field. Yet teachers pontificate. "A free spirit ought to learn no piece of learning with slavery," said Plato.

What do we have in most colleges today? The recitation system and the lecture system. Recitation becomes a sort of detective job for the instructor and a great tedium for the student who has done his reading. Much better would it be for all concerned that the student should quiz the professor. As for the lecture system, a University of Michigan student defined it as "that system or process by which the contents of the professor's notebook are transferred by means of the fountain pen to the pages of the student's notebook without passing through the mind of either."

Whatever system is used, there are four factors involved: the student, the instructor, the subject, and society. What of the first factor, the student? The aim of a student in study is to acquire knowledge, knowledge that he can *apply*. For even in purely cultural subjects he desires to make application of his knowledge to enriching his enjoyment of life. If now his brain is not quickened by activity, the activity of participation, it is limited in power to take in and to relate to life what it does take in. The difference between the merely listening and the participating student is that between the person who takes his food with pleasure amid the enlivening conversation of a dinner party, and the one who eats indifferently or reluctantly, who merely stokes because to do so is necessary to life. I am not wrong in assuming that the first person is actually better nourished—that he actually assimilates his food better? Moreover, if there is not much expression on the part of the student, false ideas are not brought out into the open to have their falseness demonstrated, and good ideas fail of the recognition that would breed a stimulating pride in the student as well as benefit instructor and subject. Given freedom, given the responsibility of his own self-development, the student of worth rises to the challenge. One who would sink under these conditions is not the stuff of which good students are made.

In nursing, especially, such an active part taken by the student is important, for a nurse must not merely have a good technic, but must be

adaptable and ready to think quickly in an emergency. If her training has kept her merely receptive, how shall she do that? Your president of last year in her address asked: "What limits and ranges are there to the nurse's function in society?" One must say those limits are far indeed, have probably not as yet been even glimpsed. But even if a nurse is a nurse only, she is dealing with the most complex organism in the world, the human body plus the human mind. It is vital that she be penetrating and flexible-minded. And she will with difficulty develop after this fashion if she does not actively participate in her own education.

I have been greatly interested in reading lately something of the work of the Danish folk high schools and in hearing about them at first hand from an American student who had some months of experience in one of the schools. Grown young men and women of the working classes, mainly agricultural, spend from three to six months at a time in these schools. The education is voluntary; there are no entrance examinations, no credits, and no diplomas; the subjects are purely cultural—history, literature, music. The teachers and the students live together in the country, in houses which become homes through their thus living together and through teachers and taught doing the outside and inside work of the household in community. About one-third of the rural adult population of Denmark has passed through these schools, which, by the way, pay for themselves. Denmark has been called the most civilized country in Europe, and its scrapping its one battleship recently shows certainly a high degree of enlightenment. Who shall say how much of the skill and intelligence which it has exhibited in making the very best of its unfavorable material position and limited resources has been contributed by the true education received in these schools where teachers and students work together as companions in a common adventure of the spirit, reading poetry or telling old legends by the fire of an evening, singing folk songs as they go off to the skating pond together?

Think of how such a plan educates the educator! He is our second factor. What could be worse for a human being, spiritually, than always assuming a position of superiority? The smugness of teachers is a blight. It arises naturally from the teacher's assumption that always in the group he is the person of superior information for which the others are receptacles. The real task of the teacher is a noble one. It is, as Dorothy Canfield Fisher says, "the awakening, encouraging, and judicious feeding of intellectual curiosity and activity." Too often, though, he struts his brief hour on the stage, making wise cracks attitudinizing, fulminating, blind to the amusement or contempt or tolerance in the shrewd young eyes before him. How different the experience at the Bryn Mawr Summer School for Women Workers in Industry, another example of humanized educational procedure. It is hard to tell which there gains the more, student or instructor. The women workers have adult brains. They have thought seriously or they would not be there. They have made sacrifices to be there. They challenge the instructor, with his often theoretical knowledge. One instructor, a man, reported that "after standing up for eight months before the somnolent daughters of the plutocracy, it is like a breath of fresh air to come here and be challenged by a garment worker." I myself had, in a drama course last

year, a student who was a graduate nurse. Her image comes vividly before me as I speak of her, that of a notably fresh-colored, immaculate, and ready person, with an air of eagerness for knowledge. She was earning her way in the University by doing night nursing, and the physical impression she made, as I have described it, becomes more significant when one realizes that the class she had with me came at 9 o'clock in the morning. Whenever we were discussing, in some play, the springs of human action, I felt at once the reality, the solid base in human experience, of her remarks and was braced or challenged by them as she agreed or disagreed. If the Bryn Mawr instructor had been conventionally lecturing, or if I had been, we should have missed these contributions to *our* education. And if the instructor is not continually educated *by his students*, how long before he will have nothing vital to teach? And if his teaching lacks vitality, how will his students in turn contribute anything essential to the education of those with whom they perhaps come to occupy the teacher's position? "If the salt have lost its savor, wherewith shall it be salted?"

The third element involved in the situation is that of the subject. And in this connection there is a great deal of practical testimony to the worth of a genuinely coöperative procedure in educational institutions. When the Student Council was created at Harvard there was a good deal of scepticism as to its probable value. Professor Greenough reports: "We were getting advice which reported a point of view we could not take ourselves: we were too old, we did not know the facts, we had not the feeling which they had." He goes on to say that "the harder you lean on the Council the stronger it gets," and he says that the administration came to find they could treat the members of the Council "like college officers." Last winter in Boston I heard Dr. Richard Cabot speak on student opinion, and in the course of his remarks he dealt with a report made by a committee of this Council, a critical report on conditions at Harvard. This was so wise and so well written that Dr. Cabot said many people thought it "must have been written by President Lowell himself!" But it was entirely student work. At Radcliffe, three days are taken at the opening of college in the autumn for the President, the Dean, and certain students in leading positions to consider in conference various projects for the increased efficiency and welfare of the college. Vassar, Princeton, and the University of Chicago all have boards of religion on which are represented both students and faculty. I speak particularly of Chicago because it is the place I know best. On the Board at Chicago are students, both graduate and undergraduate, faculty, and one trustee. This group has had in charge all the plans for the uses of the great new chapel, the choice of the Dean of the chapel and the determination of the very nature and order of services. At Chicago, likewise, the uses of the women students' clubhouse are determined by an advisory council on which students are very largely represented. The Honor Commission is a faculty-student group; and the Board of Student Organizations, Publications, and Exhibitions has at the present time a larger number of students than of faculty members. When students were first admitted to representation on this Board only graduates were eligible, and only two of those. It was considered by many of long experience on the Board that the presence of students, while matters

concerning their regulation and discipline were being discussed, would be embarrassing. So far from being true has this proved that we weigh and cherish the counsel of the large number of undergraduates now on the membership list. And note that here as at Harvard and at Radcliffe the field concerned, the very subject itself, is being developed by student participation. If it is objected that these instances deal with considerations largely administrative, I reply that the principle is the same in procedure that is more strictly educational in the narrow sense. We have, again at Chicago, instances of student contribution in the strictly educational field. Students are taking part in the work preliminary to the preparation of the unique Chaucer text which is being made by eminent scholars in the field of Old and Middle English, and also in the preparation of work for the first dictionary of the American language, undertaken under the leadership of Sir William Craigie. These are graduate students, of course; but in an undergraduate course for Sophomores, the Meaning and Value of the Arts, the last year's leader of the course, Robert Morss Lovett, is on record in print as saying that suggestions and criticisms by class members "have been made freely. All that were practicable have been adopted at once, and others filed for future use." I need not say that this student participation is not designed by the instructor to give the young people a pleasant sense of taking part—as a child might be allowed to brush up the crumbs—but to enlarge the scope of the subject itself and to bring subject and student into closer and more vital contact.

The fourth factor or element mentioned before is society itself. In his "Idea of a University," Newman said: "That training of the intellect which is best for the individual himself, best enables him to discharge his duties to society." If this is true—and I for one believe it—and we decide that this more active participation in his own education is best for the individual himself, we can rest assured of its wider value. L. P. Jacks in his "Responsibility and Culture" says: "The ultimate objective of all societies that are advancing on the path of freedom is reciprocal education," and "The final form of human society, so far as our minds are able to conceive it, is a world-wide coöperation for the development of man." The phrase "reciprocal education" seems to me a very happy and a highly significant one. But one may acknowledge the excellence of the term; one may let one's mind dwell on the implications of the word coöperation —surely a word much in the air of our day; and still one may not see how to take the next step. If we accept as an ideal of education continuous consultation and coöperation between instructor and student, how can we bring it about, how especially can we bring it about in nursing education? I am reminded of the story of an Englishman who went into a London restaurant in the middle of the war and said to the waiter: "I should like a steak, very tender, about two inches thick, well broiled but with the gravy following the knife, and a large pat of butter on top." And the waiter looked at him admiringly and said: "I don't blame you, sir." It is one thing to have the ideal and another to see a great gulf between it and its realization. We have been told in other connections that a ship must have a captain, that it cannot be navigated by a committee. Just as true is it that there must be good material, good brainstuff, well developed, if

we are to have future captains. And your president last year pointed out the increasing need of attracting to the nursing ranks women "capable of leadership in administration and education." Leadership cannot be developed all at once; it must be developing constantly all through the period of formal education—and forever after that. In the midst of the complexity and importance of the problems presented we may seize upon some enlightening words of Shaw's preface to "Back to Methuselah." They are words expressing the stages of evolution through which a new conception must pass, expressing the successive attitudes one who commits himself to the fulfilling of an ideal must take: imagine, desire, will, create.

The Out-patient Department as a Teaching Field for Student Nurses[1]

GERTRUDE S. BANFIELD, B.A., R.N.

THE Out-patient Department offers one of the richest teaching fields there is available for student nurses. Great is the pity we do not take more advantage of this opportunity! Many hospitals have Out-patient Departments which not only act as feeders to the hospital but provide examination and treatment for hundreds of patients who have early-stage conditions which are rarely found in hospitals. Is it not important that every nurse who is equipping herself to help carry on a health program familiarize herself with these early conditions as well as many other maladies which are much more frequently seen in the clinic than in the hospital? And fully as important is the opportunity for realization of the sociological conditions which are contributing factors to these maladies. How many of our students have this opportunity and just how much do they get when the opportunity is offered?

There are certain things which are essential in order to ensure the student an educational program during her service in the Out-patient Department. In the first place, the Out-patient Department, or Dispensary, where educational work is to be done, should be a well-established and well-organized institution and should offer an active service in all of its departments, including the specialties as well as general medicine, surgery, pediatrics and obstetrics, and if possible psychiatry and mental hygiene.

Secondly, there must be adequate supervision. By this I do not mean one graduate nurse who talks with the student when she first arrives, trying to explain to her in a few moments the ins and outs of the whole clinic, and then leads her to some one special department and shows her how to set up for it, leaving her to her own devices to learn what she can until it is time for her to be changed to another clinic. I am afraid in many instances this is too often the case. To be sure, if the student is a keen, alert individual she will undoubtedly grasp a lot—but what will she have been taught?

[1] Read at the twenty-fifth annual meeting of the Illinois League of Nursing Education, held in Joliet, October 19, 1928.

The supervisor of a clinic should be a graduate nurse, with executive and teaching ability, who is responsible for the nursing administration of the clinic and for the clinical educational program of each student during her service in the Out-patient Department. Her preparation should have included a sound professional background with instruction and experience in public health, out-patient work and supervision; she should have a psychological and sociological point of view and, although not necessarily a trained social worker, should have a keen sense of the social and economic needs of her patients. Many times the responsibilities of this position include the business administration of the clinic as well. I feel that these responsibilities should be placed in another with whom there is perfect coöperation. In an active clinic with the dual responsibility vested in one individual, either the administration or the nursing supervision is sure to suffer.

The supervisor should have as her assistants well-qualified graduate nurses whose training should have included, if possible, experience in out-patient work and public health. They should be permanent members of the staff and responsible for the administration of the clinic of which they are in charge and for a large part of the teaching of the students as they come to them.

The great advantage of having a graduate in each clinic, aside from the continuity of service which is made possible, is the fact that she can plan the student's work so that she gets instruction in the study of her patients and consecutive experience in the preparation, assistance and administration of the clinic. It is very important that the student have experience in the administration of the clinics in which she works, but if she is to be put in charge of the clinic as soon as she arrives, and left by herself, her first responsibility will be to see that the patients are cared for which leaves little or no time for her own study of cases.

With such a plan for supervision I come to the third essential in the establishment of a good educational field in the Out-patient Department and that is an interested and coöperative clinical staff. To be sure, we have no control over the staff, i.e., the personnel selected, but if we can assure them of uniformity and continuity of service, we shall get much better coöperation from them. If they are not going to have to be frequently instructing assistants in the little things which become routine under continuous service, but which cannot possibly become so with frequent changes, they are going to be very much more interested in demonstrating the unusual and interesting conditions as they present themselves.

The fourth essential is the presence of an adequately staffed social service department. It is practically impossible in many instances to carry out the medical plan recommended by the physicians without their assistance and coöperation. It is easy enough to *tell* the patient to eat plenty of fresh fruits, vegetables, etc., but to make sure that this is going to be a possibility is another matter. Or, how can a mother plan to come into the hospital for treatment when doing so would mean leaving children at home uncared for? You are all very familiar with the problems which arise daily and how very essential social service is in solving them. Without its presence in clinic, much of the work must of necessity be of an unfinished nature and the student is apt to fail to appreciate the possibilities

of assistance. It is social service which makes the seemingly impossible possible. If the student can take her problems to the social worker and work them out with her, how much fuller is the student's service to the patient and how much richer her experience!

And let me add here that a social service department is just as much needed in a pay clinic as in a free clinic, although on first thought this may not seem true. The patients who visit pay clinics have higher standards of living than those in free clinics, and on limited incomes there is little margin for illness and the stress of keeping up creates acute social problems.

The fifth essential is a well-planned physical plant. I grant that a lot of teaching can be done in any kind of a building; but very much better teaching can be done in a building which has been planned with a school in mind. Important features, as far as the students are concerned, are classroom space, convenient laboratory facilities and offices for the teaching staff.

The classroom, of course, affords convenient place for group discussion and instruction and also for the working up of case studies. It should be equipped with reference books covering the various services which are to be included in the student's experience. If the student's course in clinic is well-planned, the classroom will be in daily use, just as are the examining and treatment rooms.

A well-equipped and conveniently-located laboratory, in the hands of interested and coöperative technicians, not only greatly facilitates the handling of specimens but affords an opportunity for the students to follow through the examination of the specimens from their patients. How much more vividly a condition can be pictured by seeing a dark field smear of spirochetes, for instance, or the reaction of a urine specimen full of sugar, or the titration of gastric contents.

Offices for the supervisor and head nurses are exceedingly important. They are used for the frequent private interviews with the students and members of the staff, as indicated, and provide a definite place for the keeping of student records and the carrying on of the routine work which is a big part of any good organization. If one has to depend on just any space which may be available at the moment, with a more or less frequent change of place depending on the time of day, surely one's work cannot be as efficiently or thoroughly done as it otherwise might be.

In the sixth place, the students should be relieved as much as possible of the performance of non-nursing procedures by the employment of an adequate supplementary staff. In my experience, I have found that many of the routine duties which formerly were done by students can be well cared for by such a group. It is obvious that having this staff would leave much more time for educational work by the student.

And now, just what does the Outpatient Department offer which is not so readily available through hospital service alone?

Most important is the possibility of seeing the patients as human beings and members of society. It is very easy in the hospital to think of the patients as cases of pneumonia or diabetes and forget entirely that they are individuals with definite community relationships. Their physical needs are very well cared for but how much time and thought are really expended on the human side of their lives? Are we being really fair if we fail to give

our students these opportunities for the realization of the social aspects of their patients? In clinic, the patient comes in with some member of his or her family, or a friend. At once a realization of a relationship of the patient with his family is established in the mind of the student. All appointments for return visits are so planned as to cause the least inconvenience to the patient, remembering always that he has definite outside responsibilities. In the patient's reaction to instruction regarding diets and treatments, an appreciation of home conditions and their limitations is apparent to the student. I could enumerate indefinitely the situations arising daily which keep ever before the mind of the student the fact that her patients are people with definite social responsibilities. Visits to patients' homes open a student's eyes even more to the conditions other than medical which contribute largely to human ills. They awaken in the student that social sense without which she goes about her work with great limitation. A nurse may be able to give treatments beautifully, to keep her ward in perfect order, to plan her work with great efficiency; but if she fails to show to her patient a sympathetic interest and understanding, she is failing in one of the greatest things she should offer in her professional service. Surely a clinic with its definite relationship with the community is the laboratory for developing socially-minded nurses.

Another important thing which the Out-patient Department offers is the opportunity of familiarizing oneself with the various health and social organizations which are all so closely related, each one ready to help where some other one's responsibilities end. I am afraid many of our students are graduated knowing these organizations only by name, if they are so fortunate as to know they exist. Their working plans, just what fields they cover, how to obtain their aid, are quite unknown. In clinic, many times, the students have opportunity of caring for patients who have been brought in by a member of the Visiting Nurse Association or school nurses or some charitable organization, but in the ward this association with members of other organizations is unappreciated. In clinic, the referring organization is nearly always represented, making opportunities for establishing a personal relationship. There is no branch of the profession which the student may follow after graduation in which her usefulness and service will not be greatly increased if she is quite familiar with these aids at her command.

To repeat what I mentioned briefly in the first paragraph, one of the most important things offered in the Out-patient Department is the opportunity to observe and learn to recognize various pathological conditions in their early stages. To be sure, it is exceedingly important to know how to care for and treat these conditions once they are advanced enough to necessitate hospitalization, but is it not equally or even more important to be able to recognize the incipient conditions and to help prevent their development? The fields of public health, school and industrial nursing must be staffed with young women who have been educated in the Department of Preventive Medicine. Where better can our nurses get this than in Out-patient Departments?

And, too, the Out-patient Department offers by far the best opportunity for observation and study in such specialties as eye, ear, nose and throat, dentistry and dermatology. Few patients in these departments are

admitted to the hospital other than those having operative or very acute conditions. A wealth of material is never observed by students which represents the common conditions one meets every day. How much more valuable a nurse's service would be if she could appreciate, for instance, what an ear-ache might mean to a child. In clinic, where she sees many perforated drums and draining ears, she cannot help but realize the seriousness of the aftermath of many acute infectious diseases both in loss of physical well-being and in the social problem which is often created. How many of our students have an opportunity to see and recognize secondary luetic rashes and watch them respond to treatment—or how many of them appreciate the importance of getting the entire family under observation once a specific diagnosis is made? They are all taught these things, but it takes study and experience in the field to make for keen appreciation. Is it fair to expect them to know how to cope with these ambulatory conditions if we do not afford an opportunity for observation and study?

Although my subject does not include the discussion of the curriculum, in conclusion I cannot help mentioning the question of where Out-patient Department experience should come in the student's course. This is still a debatable point. Some feel it should come during the Junior year. The chief advantage of having it come early seems to me to be that it enables the students to become familiar with or cognizant of the social aspects of their patients, and this certainly is a very vital factor in their future work. It is almost impossible to expect them to get this social sense in a short space of time crammed in to the last part of the Senior year.

The chief objection to having it come early is the fact that the students have neither the judgment, experience nor knowledge to do the health teaching which is one of the most important parts of their daily work in clinic. It is to the nurse the patients turn to have answered the many questions which have been filling their minds. The Junior is not equipped to give them the help they need. The younger the nurses in clinic, the greater the amount of supervision necessary on the part of the graduates.

There is a considerable attempt to correlate medical out-patient work with medical ward work and courses on medical nursing, and surgical out-patient work with surgical ward work, etc. Whether this is going to prove of more educational value to the student is yet to be seen. It does seem that the Out-patient Department offers so much more than just the medical and surgical theory and practice that it is of great value as an experience in itself.

During my past year's experience in working with graduate nurses, I have been greatly impressed with the keen interest and desire for work in the clinics. Many of them have not had this work during their courses. In many instances, I think they feel they have missed something very vital. Their expressions open one's mind to the possibilities of and need for courses for graduate nurses in out-patient work.

But wherever, in the curriculum, this experience may come or whether there be correlation with the ward work or not, or whether it be offered as a course for graduates—wherever the facilities are available, let us try to take advantage of them.

Staff Education for Institutional Nurses[1]

M. CORDELIA COWAN, R.N.

SUCH a meeting as this gives evidence that nurses are cognizant of the same truth that led David Starr Jordan to utter the words, "He who would be wise must daily earn his wisdom." In all walks of life, trade, industry and the professions, we are seeing and hearing much about this daily earning of wisdom in the so-called training in service. It is therefore not strange nor unusual that nurses are also interested in this present trend in education. This training in service for institutional nurses dates back to the beginning of our first nursing organizations which had this as a main object in their organization, the coming together for mutual benefit that they might learn from each other. And, just as the organization movement had its inception in the banding together of the members of one institution to form an alumnae for mutual benefit, so now does this educational movement come back to give aid to the members of each individual institution. With the increase of our numbers, greater complexity of work brought about by the scientific discoveries of the age, and the increase in size of our institutions, we must bring our educational program nearer home to help in solving the many problems which confront us.

Today there are two groups of institutional nurses that especially need the help we may be able to give them, namely—the general duty group and the head nurse and supervisor group. With all the changes in conditions, these groups, out of all the nursing personnel of our institutions, have had less help in this respect. Should we not be taking the problems of our general duty nurse a bit more seriously and attempting to understand her as an individual? Would this, too, not give us a greater insight into the valuable service which she is rendering, give her the recognition which she deserves, restore the respect for this type of work, and gain her confidence and coöperation? Human nature is human nature. The nurse is no exception as she, like others, tends to measure up in proportion to the faith placed in her ability and what is expected of her. Almost nothing, as yet, has been done for this general-duty group to make them feel that they are rendering a service that is just as valuable, if it is well done, as the service rendered by any of the members of the administrative and teaching groups.

Some measures have been attempted to lighten the burden of the head nurse and supervisor group by taking certain amount of responsibility from them and assigning it to others, to the teaching supervisor and the instructor of nursing practice, who spend a part of their time on each ward. This, in a number of respects, has not been entirely satisfactory, as it has brought about an overlapping instead of a division of responsibility that has seemed to decrease the interest which the head nurse and supervisor felt in this part of their work, and from which they derived considerable satisfaction in their particular jobs. Thus this innovation has, in some respects, increased rather than decreased the problems of the head nurse and supervisor.

On the other hand there is still much to be accomplished in relieving the head nurse and supervisor of

[1] Read at the annual meeting of the New York State League of Nursing Education, Brooklyn, 1928. Read at the November meeting of the New York League of Nursing Education.

non-essential duties which they perform, such as running errands of various sorts, going to the supply room for supplies, checking and putting away supplies, getting supplies ready for sterilization, and general routine ward work, all of which might be relegated to others and allow more time to do those things that would make their work more satisfying to them in that it would hold greater benefits to the patient.

Need we wait much longer before doing something to help them with their increasing problems which they have to meet, as well as learning something of these problems ourselves? In the study of the head nurse and supervisor which has been carried on this last year, under the Committee on Education of the National League of Nursing Education, some very interesting points were disclosed about what the nurses themselves thought of their work and their own need for help. Practically all the questionnaires answered by head nurses and supervisors stated that they felt the need of further advanced work in the special field in which they were engaged and in many matters of ward management, supervision and teaching. What an abundant field it offered for the gathering of topics for an educational program!

The way in which such a program can best be handled is naturally limited by lack of time and the availability of those qualified to carry on such a program. Some of the ways that might be suggested for this are as follows:

1. Specially-planned courses in some university or college.
2. A carefully-worked-out series of programs fostered by the District Association for its members or by an Alumnae Association interested in carrying out such a program for its members and the personnel of its own institution.
3. Staff conferences under the advice and guidance of some qualified person, either from the institution or from the outside.

Since the last-mentioned suggestion holds the greatest feasibility for all, we will turn our attention to some of its possibilities for both groups, whose interests are, and should be, much the same, for the general duty nurse should be as keenly alert to carry her share of professional responsibility as is the head nurse or supervisor.

Some rather pertinent and useful information about staff conferences was obtained from asking a number of general-duty nurses, head nurses, supervisors, instructors, and directors of schools of nursing. General duty nurses, for the most part, have not had much experience with such conferences unless they have at one time done some supervisory work, so that little was gained from them.

A good many of those in the higher administrative and teaching positions stated that there seemed to be a lack of interest in conferences and that the nurses failed to enter into the discussions; although they knew that they discussed things freely afterwards, out of conference, and often had wrong ideas about many things that the discussions should have cleared up for them. Of most vital importance, however, were the answers from the head nurses and supervisors, among which were

1. That they often did not feel that they knew enough to discuss that which was in question.
2. That they hesitated for fear they would say the wrong thing.
3. That they lacked confidence in their own ideas.
4. That they did not always feel free to express themselves but instead seemed to "tighten up."

This last expression probably explains best their failure to enter into discussion and their inability to do so

in that state of mind, as they felt themselves "tighten up" as they expressed their feelings. The expression reminds me of a story that they tell of "Lindy." When he was flying over Ireland a bolt loosened, and began to rattle. As he went on, while flying over England, two more bolts loosened and began to rattle. He was about on the point of making a landing when he perceived that he was passing over Scotland and they all "tightened up." Would it not be a good thing for us, in our conferences, to remain "over Ireland and England" for a spell and get loosened up?

There must be many ways of making our conferences more democratic. In our experience last year at the Woman's Hospital we found one way of doing so, in the evaluation of our nursing procedures. The greater share of the time of our head nurses' and supervisors' conferences was spent in this way, trying to improve our procedures for the revision of our Manual of Nursing. Because these conferences served such an exellent purpose in getting the group "loosened up" I shall relate very briefly the method which was followed for that series of conferences.

Our criteria for evaluation of the procedures were similar to, but not quite the same as, the eight standards first set up by Miss Stewart, as outlined in an article in the June issue of the *Modern Hospital* for 1919. Ours were as follows:

1. Safety.
2. Comfort and happiness.
3. Therapeutic effect.
4. Economy of energy of patient, nurse and other workers.
5. Educational value to patient and nurse.
6. Economy of time.
7. Economy of materials.
8. Flexibility of standardization to give adaptability and simplicity.
9. Logical sequence for neatness and finish.

At each conference the procedures for the following conference were announced and any suggestions for changes requested. At the next conference there were given demonstrations of the old method, followed by demonstrations of suggestions offered, and the matter was put to a vote for its trial on the ward. After ample observation, a few minutes of a later conference were used for discussion of these procedures as they had worked out on the ward, and if no further changes were suggested, the points in question were voted upon for rejection or acceptance as a part of our revised routine.

In these conferences the participation in the discussion was excellent. Being individually concerned in the matter, as it applied to her own particular ward, gave a great impetus to each one to express her own views, thus these conferences not only served the purpose of improvement of procedures, but led to free unrestrained utterance as well.

Much could be said about the topics to be included in such a program but time will not permit. However, copies of an outline for such a program, that has been worked out, are available for those who care to have them. (See copy at end of article.)

Equal importance should be attached to the way in which a program is to be carried out and this decision should rest with the group itself. Some alternatives that might be suggested are:

1. A specialist in the field called in to conduct the conferences like a course of study.
2. Members of the group designated to take turns in conducting the conferences.
3. A coöperative plan in which the whole group is divided into small groups of two to six members and each of these small groups in turn conducts a conference assisted by the educational director, or someone who can act in the capacity of educational consultant, to advise in getting the necessary materials

together and give aid in the organization of their program.

The plan last mentioned gives participation, which is so important to interest, and relieves much of the heavier burden without decreasing this interest and the satisfaction of those participating. Such a method holds also the opportunity for development of the possibilities of leadership in our younger nurses.

The time of the conference is still another matter of importance. If the nurses are to receive the greatest benefits and satisfaction from them the conferences cannot be held in the evening after a hard day's work. Nor, from the standpoint of interest and importance to the hospital itself, should leisure hours be used. If an afternoon hour is not possible, at least an additional hour can be given for recreation during the daytime, so that the conference hour does not infringe on this time. The institution should value the conference sufficiently to allot the necessary time during the time on duty, as is the custom in business and in our school systems. Such valuation placed by the institution will do much in increasing the valuation of the conference in the minds of the workers.

There is much to be gained by staff conferences not alone for general-duty nurses, head nurses and supervisors, but for the entire nursing personnel.

1. The conferences should give an insight into the problems of these groups and thereby a better knowledge of what help they need.

2. We should be able to guide them to a clearer conception of the fundamental principles of good ward management, supervision, and teaching. To quote Dr. Judd, in his address at Louisville, "the last twenty years have brought more progress in methods of training the human mind than was ever made in any earlier century of the history of the race." And the nurse is first, last and always a teacher.

3. Through the conferences these groups should be given a fuller comprehension of their particular jobs, their responsibilities, obligations and opportunities.

4. Individual growth can be fostered through an opportunity for participating in the conferences and the encouragement to do so.

5. Staff conferences can lead to a better understanding of human nature and its management through the coöperative efforts of the whole group.

6. Staff conferences can help meet some of the urgent needs of these groups through the selection of these matters as topics for the program to be followed.

7. Ultimately, there can be obtained a greater unity of purpose in all that we are trying to do by making these nurses feel that they too have as important a part to perform as do the others of the administrative and teaching personnel. In this way we can provide for a growth of better understanding of our problems and a unified effort to solve them.

In conclusion I will summarize briefly some of the most important points that have been brought out in the planning and conducting of staff conferences.

1. Meet the immediate needs felt by the nurses themselves in formulating a program.

2. Let the topics be selected by themselves, with someone only to guide and advise but not to dictate in the matter.

3. Plan to give everyone a chance to participate, even though the share be ever so small. Each one of them becomes a part of the group, participating in its activities and learning the satisfaction of such participation.

4. Arrange the topics so as to start out with those in which all will be interested, about which they will know something, and which they will feel no hesitancy to discuss.

5. In all ways make the group feel that the conferences are indeed their own, by them, and for their own purposes. Give them their chance and see what they can do. I am sure we shall not be disappointed.

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Evaluation of Nursing procedures.

Study:
- Principles of learning.
- Methods of study.

Bibliography of obstetrics and gynecology:
- Use of books.
- Book review.

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- Observations of the teaching in other schools.
- Grading.

Supervision:
- Supervisory plan for routine ward activities.
- Bedside clinic demonstration.
- Supervision of the special nurse.

Management:
- Principles.
- Ward housekeeping.
- Planning assignments to use educational features of the service.

Management of patients.

Mental hygiene.

Emergencies peculiar to obstetrics and gynecology.

Testing of apparatus.

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Delano Recruiting Week

TO maintain the Red Cross Nursing Service at its highest state of efficiency, a constant influx of graduate nurses into the enrollment is required. In order to be prepared to meet the needs of the American Red Cross in its disaster work, its rural nursing program, as Instructors in Home Hygiene and for such other Red Cross activities as may arise from time to time, as well as to supply the depletion from natural causes, at least 150 nurses should be enrolled each month.

Consequently, the week terminating on March 12, Miss Delano's birthday, has for some years been used as a fitting occasion upon which to emphasize the needs of this service, as well as to enroll new candidates. As this anniversary has been observed for several years the nurses throughout the country are fairly familiar with the necessary plans. The work should focus in the schools of nursing, for the present student is the Red Cross nurse of tomorrow. To her we must look for our recruits and our future leaders in Red Cross Nursing. It will not start there, or for that matter in any other particular place, unless the Local Committee develops a practicable and workable plan which will be acceptable to the directors of such schools and will interest the students. It goes without saying that a strong local committee is the first requisite in connection with the movement. The members of the Local Committee on Red Cross Nursing Service might well take the lead, or if there are none in a given locality a Red Cross nurse might start the movement. In coöperation with the local League of Nursing Education, the District Association of Graduate Nurses, the Red Cross Chapter and other interested groups, a plan of procedure should be developed, culminating on March 12, in some fitting celebration. It might take the form of a big rally of Red Cross nurses with inspirational speakers, a procession, etc., afternoon teas or receptions, or the utilization of district meetings, alumnae meetings, etc., for some special observance of the occasion. Student nurses should take a leading part in all celebrations.

The plan should include the study by the Senior classes in schools of nursing of the Red Cross Nursing Service, the origin of the Red Cross idea, or the life and service of Jane A. Delano. A particularly good essay might be read at some public observance, while plays, pageants, etc., which have been written by student nurses might well be utilized upon some of these occasions. A letter to all Local Committees bearing upon this subject has already been sent, while a complete account of the purpose of this movement appeared in the *American Red Cross Courier* of February 15. The "History of the American Red Cross Nursing Service," published by the Macmillan Company, New York City, and "The American National Red Cross, Its Origin, Purposes and Service," by S. Elizabeth Pickett, should be used for reference purposes.

Disaster Preparedness

THE American Red Cross is making one of its objectives this year better preparedness plans for disaster, consequently the Nursing Service has prepared very careful instructions for its Nursing Field Representatives and others who may be used to supervise the nurses in connection therewith. As there are many minor disasters which may not need a nursing supervisor, special instructions covering nursing to guide the General Representatives who may be sent to the disaster area have also been issued. Instructions for the guidance of Local Committees in their selection and assignment of nurses have been used for several years. These are also being subjected to revision. An interesting leaflet prepared by the Chapter Chairman of the Southeastern Chapter, Philadelphia, Pa., showing the rise and curve of disasters in the United States in which the Red Cross has participated, furnishes interesting matter for thought.

During the ten-year period, 1905–1914, there were 39 disasters in which the Red Cross functioned. In the five-year period, 1924–1929, the Red Cross assisted in 289 disasters. Surely no further evidence is needed to convince the American Red Cross that its preparation to cope with these great disasters should have no weak spots.

Where Red Cross Nurses Report When Disasters Occur

WE again wish to call the attention of all Red Cross nurses to the importance of communicating at once with the nearest Local Committee when they hear that a disaster has occurred in the territory where they reside. Nurses, because of the nature of their work, are rarely to be found at the same place for any length of time, therefore a great deal of time will be saved if the nurses report to the committees instead of waiting to be called. It goes without saying that if nurses are required, they are usually needed at once. Promptness in filling this need may save untold suffering on the part of the victims.

We are also asking the committees to clarify their enrollments:

First, by eliminating all nurses who have not answered their questionnaire for two years, by sending their No. 2 cards to National Headquarters or the Midwestern or Pacific Branch Office, as indicated.

Second, by classifying the enrollment, separating those above the age, physically disqualified or married, who are therefore ineligible for active service.

Third, by building up within their enrollment emergency units composed of nurses who would be quickly available for emergency work.

A letter elaborating these suggestions has already reached the committees.

Delay in Completing Enrollments

NATIONAL Headquarters and the Local Committees are frequently accused of holding up applications for enrollment. This might not be necessary if care were exercised in making out the application blank by completely answering each question. The most frequent cause for delay is due to failure on the part of directors of schools of nursing to return promptly the training school credential, which is required for all applicants. Again and again our committees, composed of busy women, complain that they are obliged to write several times for such credentials. While we understand quite fully the heavy demands that are made upon directors of schools in

connection with questionnaires, etc., this particular credential requires no research work and could be easily completed by consultation with the training school record. May we again urge the coöperation of the directors of schools of nursing in this particular? Delay in returning a credential may seriously affect the nurse who applies, for she may be desirous of serving as a Red Cross public health nurse; furthermore the Red Cross is subjected to censure; it is always blamed for these delays, and not the director of the school of nursing.

Annual Convention of the American Red Cross

FOR the first time, the National Red Cross holds its convention in the Spring, April 22–25, inclusive. State Associations are entitled to send delegates to this convention. We hope the states will appoint these delegates, if they have not already done so, notifying the Red Cross to that effect. It is a beautiful month in which to visit Washington, consequently we hope that many Red Cross nurses or others, whether they are delegates or not, will plan to visit the city at that time. We extend a cordial invitation to all.

Facts about the American Red Cross

WE wonder how many readers of the *American Journal of Nursing* know that 602 chapters of the American Red Cross are either conducting or participating with other organizations in the conduct of public health nursing services, largely in rural communities, and that 813 Red Cross public health nurses are engaged in this important service. Three of these services are in our insular possessions—the Philippines, and the Virgin Islands in St. Thomas and St. Croix. In the former instance the Manila Chapter on November 1, 1928, employed sixty nurses scattered among forty-six separate localities in thirty-nine provinces. With the exception of the Director of the Service, who is an American nurse, the others are all natives.

It may also be of interest to learn that in the month of December, 1928, there were 1,160 Red Cross Nurse Instructors authorized to teach classes in Home Hygiene and Care of the Sick, and that the number of classes during that month was 1,667 which were attended by 31,111 students.

The Red Cross has recently adopted a very becoming blue felt hat for its public health nurses. Members of the executive staff at National Headquarters are also using these when the occasion arises. Red Cross nurses may, by writing to National Headquarters, secure the address where these can be purchased.

Nurses are still writing for information regarding the field uniform, especially those who are members of Nurses' Posts of the American Legion, and who want to be in full and complete uniform on special occasions such as funerals, etc. Printz-Biederman of Cleveland, Ohio, still has a large stock of these on hand which he is selling at a very low price. Slight alterations in the length, width, etc., of the skirt, as well as in the coat can be made by any local tailor at very small cost. We advise nurses who desire to be properly uniformed to write direct for prices.

Student Nurses' Page

A Case Report — Measles

EVANGELINE BENNETT

A Student from Wyckoff Heights Hospital, Brooklyn, Affiliating at Willard Parker Hospital, New York City

Name: John Doe
Age: 2½ years
Case no.: 2237
Diag. on admission: Measles
Successive diag.: Nephritis, cystitis, nasal diphtheria.

Definition of Measles

A WIDELY prevalent, highly communicable, epidemic disease, characterized generally by a rise in temperature, cough, coryza, and conjunctivitis, a typical eruption and Koplik's spots, and a marked tendency toward secondary infection.

Outline of Main Points of Disease

The exciting cause is thought to be a filterable virus of rather slight viability, present in the secretions of the nose, throat, and eyes and in the blood during the eruption.

Exciting Organism

Not definitely known, but may be: Dr. Tunnecliff's small gram positive diplococcus; Drs. Carronia and Sindonis' anaerobic gram negative micro-organism; Dr. Degkwitz's ultra microscopic organism.

Incubation Period

Is the period between exposure and the onset of the symptoms.

Duration depends on:

1. Virulence of the organism.
2. Resistance of the patient.

Average length 10 days, outside limits 7–21 days.

Methods of Transmission

1. Direct contact during the invasion.
2. Indirect contact by articles freshly soiled with the secretions of the patient.
3. Droplet infection.

Source of Infection

The invasion of the exciting organism into the mucous membrane of the nose and throat.

Period of Communicability

1. From four to five days before the appearance of the rash to five days after the appearance of the rash, provided no complications or catarrhal symptoms are present.

2. From the onset of the catarrhal symptoms until such a time as they have abated.

Methods of Diagnosis and Symptoms in Order of Their Appearance

Twelve-hour intervals, except the rash which appears 36 hours after the appearance of the Koplik's spots.

1. Fever.
2. Puffiness of the eyelids, injection of the peripheral conjunctiva, enanthem of the mucous membrane of the pharynx.

3. Conjunctivitis, coryza, cough.
4. Koplik's spots over the buccal mucosa.
5. Rash.

General malaise throughout.
Average length of attack 8–9 days.

Immunization

1. Natural (unusual—denied by many authorities).
2. Inherited—present only if mother had measles—duration 5–6 months.
3. Acquired:
   a. Active following an attack of the disease, usually permanent.
   b. Artificial—obtained by inoculating with vaccines infants who are still immune by inheritance. (This is still in the experimental stage.)
4. Passive—obtained by the injection of a specific serum usually from a convalescent patient, duration 2–5 weeks.

Isolation

Should begin on the first diagnosis of measles and end five days after the appearance of the rash, if there are no complications or catarrhal symptoms present. Ideally, isolation should start with the first sign of catarrhal symptoms, as it is during this time that measles are so highly contagious.

Complications

Otitis media
Mastoiditis
Bronchopneumonia
Cervical lymphadinitis
Febrile albuminuria
Laryngitis
Ileocolitis
Sinusitis
Purulent conjunctivitis
Meningitis.

Sequellae—Tendency to

Tuberculosis
Pertussis
Relapses or reoccurrences
Susceptibility to other communicable diseases such as diphtheria or scarlet fever.

Convalescence

Uncomplicated cases: Temperature falls after the appearance of the rash by crisis or rapid lysis and remains normal. All other evidences of the disease clear up rapidly except the pigmentation and cough which may last one to two weeks. Children regain strength rapidly, adults have fatigue for a few days. Immune bodies are thought to diminish or disappear from the blood during or soon after an attack of the measles, thus rendering the patient very susceptible to another communicable disease.

The patient may get up when the rash and fever are gone and isolation may be discontinued a week or ten days later.

Preventive Measures against Complications, Secondary Infection and Spread of the Disease

1. Early recognition of symptoms and diagnosis.
2. Isolation at first evidence of catarrhal sypmtoms.
3. Cleanliness.
4. Special care of the nose, mouth and eyes.
5. Daily inspection of the ears.
6. Plenty of fresh air and sunshine.
7. Concurrent and terminal disinfection.
8. Prevention of chilling.
9. Isolation of all contacts for the length of the incubation period.

History of the Case

Name and diagnosis: See beginning of report.

Social facts relating to health problems:

Family consists of father, mother, 2 brothers, one of whom is a baby 4½ months old, and the patient.

The father is an automobile mechanic, earning $36 a week, a high school graduate. The mother has had three years' training in a pediatric hospital in Pennsylvania.

The family occupy a suitable hygienic apartment built by the Metropolitan Life Insurance Company. It consists of four rooms, bath, and kitchenette which contains a breakfast nook.

The two boys were taken to a settlement house while the mother was

confined in a hospital. At the settlement house the boys became infected with scabies and their heads with pediculi. The brother later was discharged on release from the settlement house, acutely ill, body and head very

Days of Illness (Max. and Min. Temp.)	*Diet and Medical Treatment*	*Excerpts from Nursing Notes*
		Admitted in poor condition. Routine admission consisting of:
5th day		
T.100–120–28	Force fluids	Physical examination
	Cough mist. oz. 1, q.4.h.	Sensitivity test
104–136–30	Milk Mag. oz. 1 stat.	Schick and Dick tests
		Nose and throat cultures
		Vaccination
		Specimen of urine to laboratory
		Admission bath
		Face covered with a discrete maculo-papular rash, body dirty, head filled with nits and pediculi.
		Nasal discharge, coryza, photophobia.
6th day	Sod. perborate sol. q.2.h.	As mouth wash. Gums inflamed.
103.6–128–24	Boric acid sol.	As eye wash for conjunctivitis
	X-ray of chest	For purpose of research and to determine the presence of bronchial pneumonia. Condition fair, very restless. Takes fluids well.
105–140–30	Total amt. fluids, 800 c.c.	
7th day	Milk mag. oz. 2 stat.	Condition unchanged. Fretful. Gums much better.
101.4–112–24	Fluids 785 c.c.	
	Antitoxin 10,000 units	Profuse nasal discharge, blood-tinged. Nose and throat cultures.
102–140–28		Chest x-ray negative for pneumonia.
8th day	X-ray of chest	Rash fading. Excoriated area on upper lip
99–116–24	Semi-soft diet	and around nostrils.
	Gentian violet 2 per cent,	Distress on voiding and frequency.
101.4–90–22	gtts 1, q.4.h.	
	Nose suctioned	In each nostril.
	Hot compresses	Over bladder region, with relief of pain.
10th day	Bladder irrigation of boric	Returned with old purulent mucoid material,
99.8–92–22	acid sol. 4 per cent.	tenacious in character.
	Instillation of Mercurochrome 4 per cent.	Retained 20 min. voided oz. iss.
101–104–24		
	Hot compresses over suprapubic region, 20 min. out of every hour	Cast found in urine. Sent to lab.
		Still considerable pain in bladder region.
		Rash entirely faded. Condition fair.
	Fluid intake 585 c.c.	Nasal discharge less purulent.
		Appetite poor.
12th day	Soft diet	Returned cloudy with shreds of mucus.
99.8–88–20	Bladder irrigation	
	Instillation Mercurochrome 7%	Retained ½ hr. voided oz. 3, sent to lab.
102.6–100–24		Child dull and listless.
	Hot compresses continued	Voiding better. Total 350 c.c.
13th day	Bladder irrigation continued	Cloudy return from irrigation.
99–90–20	Instillation continued	Voiding with difficulty, severe pain.
	Hot compresses continued	General condition fairly good.
99.4–100–20		
15th day	Bladder irrigations discon-	No pain. Output normal. Very comfort-
98.2–84–24	tinued	able. Condition good.
99.8–116–24		

dirty. He was attended at home by a private physician.

John was brought to us after the settlement house had been quarantined for ten days because of an outbreak of measles.

Signs and symptoms relating to the diagnosis of measles on admission:

1. Temperature 104°F.
2. Coryza
3. Koplik's spots
4. Discrete maculo-papular rash over face
5. Metallic non-productive cough
6. Nasal discharge
7. Throat red and injected
8. Glands of neck enlarged
9. Lungs negative.

Symptoms relating to the diagnosis of nephritis and cystitis:

1. Pain in bladder region
2. Retention of urine and frequency
3. Cast found in urine
4. Return from bladder irrigation, old purulent mucoid material tenacious in character
5. Laboratory findings:
   - Pus and epithelial cells
   - Urates
   - Oxalates
   - Crystals
   - Albumin
   - Alkaline reaction.

Symptoms relating to the diagnosis of nasal diphtheria:

Profuse blood-tinged nasal discharge which excoriated the upper lip and nares.

Positive nose cultures.

Medical Treatment and Nursing Care

This case was discharged a week and a half later, fully recovered as to diphtheria and measles. He will have to be under medical supervision at home for the kidney condition which was apparently of long standing.

Health Habits Taught:

Regular habits of eating, sleeping and evacuation.

To eat slowly.

Not to put articles in his mouth, ear, or nose.

Child too young to teach very much.

Instruction to Parents against Future Illness:

Continue habits taught in hospital.

Plenty of fresh air and sunshine.

Special diet according to doctor's orders for kidney condition.

Frequent visits to doctor to check up on kidney condition.

Avoid exposure to other communicable diseases, especially tuberculosis.

Convalescent Problems:

Mostly to regain such a state of health that the body will once more build up a resistance to disease. Constant attention to the kidney condition under the supervision of a competent doctor. He should be taken to the country for the summer where he will have plenty of sunshine and acquire a coat of tan.

Possibility of the Parents Carrying out the Instructions Given:

As the parents are intelligent and interested in the children's welfare, there is every possibility of their following the advice given to them by the doctors and nurses. The mother has trained the children well and is familiar with the care of children from the hospital point of view.

Social Service:

Not referred because of good environment.

Bibliography

Dr. Stimson's Blue Book on Communicable Disease.

Rosenau, "Preventive Medicine and Hygiene."

Osler, "Principles and Practice of Medicine."

NOTE.—The routine nursing care at the Willard Parker for all cases is a daily bath, special attention to the eyes, nose, mouth and ears. Cleanliness and aseptic technic in the individual unit are stressed. The face and hands are also washed before each meal.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

THE *Journal* receives many questions, so many that they frequently have to wait a considerable time before we have space to print the replies. Recently we have received a number of questions—unsigned. Unsigned communications are really not worthy of consideration, as they indicate cowardice of one sort or another, and cowardice is not a characteristic of good nurses. Furthermore, they make it impossible for the editors to send replies by mail, as they would often gladly do if the address were at hand.

A Foreign Nurse Appreciates the "Journal"

AFTER a conversation we had together in Helsingfors, you very kindly advertised in the *American Journal of Nursing* that Belgian nurses would be so very glad to receive, in second hand your magazine. I want to mention to you that a great number of American nurses answered to your appeal and that many Belgian nurses enjoyed reading English for some time.

I wish now you could ask through the *Journal*, the name of the person who since three years sends me every month the magazine. I wish I could thank personally that too modest person and tell her how useful the magazine is for teaching purposes. Our student nurses enjoy reading it and it's also a good exercise to practice English.

I hope you will be kind enough to answer to my call and with many thanks to all American nurses who have done something for their Belgian sisters, I remain

Sincerely yours,

C. MECHELYNCK,
Directrice Generale.

Association des Infirmières Visiteuses del Belgique.

Historical Sketch of the International Council of Nurses

THE sketch of the history of the International Council of Nurses appearing in the January number of the *American Journal of Nursing* was prepared from reference to as many and as unimpeachable sources as possible, in the hope of getting some of the members who had made that history to put into print some of their own memories of it. Heretofore there had been nothing between two covers embracing the whole history from 1899 to the present day, except the very brief sketch in the *Public Health Nurse* for July, 1925, and for November, 1928. Nothing was found about the clouded years between 1915 and 1922 when the Renaissance began, and so things were purposely left indefinite. Information has now been sent in that Mrs. Henny Tscherning of Denmark was elected President in 1915, and served until the meeting in 1922 when Baroness Mannerheim of Finland took her place. The Danish nurses have done a great deal for the Council ever since their affiliation, and we are glad to know that a President from their country helped hold the Council together when things looked so black.

The latest figures furnished by Miss Reimann on membership make our total nearly 132,000, which shows us of how great a company we are a part.

More references may be added to the bibliography as published:

American Journal of Nursing, Vol I, pp. 114, 151, 294, 317, 373, 510, 675, 861; Vol XV, pp. 903–907.

If anyone notices any further errors or omissions in the article, the author will be only too grateful to know about them, for we are all trying to make records complete while some of the early members are still with us.

NINA D. GAGE.

"Journals" Wanted

LOUISE THOMPSON, Librarian, 51 Warren Avenue, West, Detroit, Mich., wishes to purchase copies of the *Journal* for October, November, December, 1917.

Sister Louise, Superior, O'Conner Sanitarium, San Jose, Calif., wishes to purchase copies of the *Journal:* 1918, June; 1919, June; 1920, October; 1924, April.

Questions

What are the requirements for joining the Nursing Service of the American Red Cross?

Answer.—These requirements have been published in the *Journal* many times. The minimum requirements which must be met for general enrollment are as follows:

Nursing Education. The applicant must be a graduate of an accredited school for nurses giving at least a two-years' course of training in a general hospital, which includes the care of men and children, and has a daily average of at least fifty patients during the applicant's training period. Graduates of training schools not meeting these requirements will be considered for enrollment if they have had six months' affiliated or postgraduate training in a general hospital which meets our requirements. Graduates of special hospitals, such as Psychiatric, Children's, Tuberculosis hospitals or hospitals caring for women only, are not eligible for enrollment unless their experience includes at least nine months' training in a general hospital, including the care of men, women and children and obstetrics, either during their course of training or subsequent thereto. Subsequent postgraduate training or hospital experience which supplements deficiencies of training such as one year of service in a Government hospital, may be accepted as an equivalent by the National Committee upon recommendation of a local Committee on Red Cross Nursing Service. Subsequent training or experience in Public Health Nursing may also be accepted by the National Committee, under exceptional circumstances, as an equivalent.

Registration. In states where registration is provided for by law, the nurse applying for enrollment in the Red Cross must be registered.

Affiliation. Membership in a nursing organization affiliated with the American Nurses' Association is a requirement. The applicant must be a member of the National Organization by affiliation through her Alumnae, District and State Associations. If a non-resident member of an Alumnae, the applicant should be transferred to be a member of the Association in the State in which she is living.

Citizenship. A nurse applying for enrollment must be a citizen of the United States. An applicant born in this country is a citizen of the United States, regardless of her father's nationality.

Age Limit. Applicants must be at least 21 and not over 45 years of age.

Married Nurses. Married nurses are not eligible for general enrollment in the Red Cross Nursing Service.

Personal Interview. An applicant, at the discretion of the Local Committee on Red Cross Nursing Service which received her application, may be required to hold a personal interview with a member of the committee or a representative appointed by it.

Physical Examination. A physical examination certificate must be filed with the enrollment application. Immunization against typhoid, para-typhoid, and smallpox is also required when an applicant is assigned to service of a nature which renders such precautionary measures desirable.

Endorsement. Each application must be accompanied by a credential endorsed preferably by the present Superintendent of the training school from which the applicant graduated or by the one under whom she was trained. This credential will be obtained by the Local Committee completing the papers. As membership in a nursing organization affiliated with the American Nurses' Association is required, a credential form signed by at least two officers of such an organization, will also be obtained by the Local Committee completing the papers. If the applicant is accepted, she is expected to continue her membership in such a nursing organization in order to continue eligible for enrollment as a Red Cross nurse. The application is approved by the Local Committee on Red Cross Nursing Service, endorsed by at least two members of that Committee, and then forwarded direct to National Headquarters or to the proper branch office of the American Red Cross. Final decision in regard to all applicants rests with the National Committee on Red Cross Nursing Service, and applications must be approved by the Chairman of that Committee or by a member designated by the Chairman.

Abstracts

A. G. Nicholls, M.D.: The New Worship of the Sun. (Delaware State Department of Health, *Health News*, September, 1928.)

WHILE these researches (on cod-liver oil as a specific in rickets) were going on, Dr. Huldchinsky, of Berlin, also working on rickets, made the remarkable discovery that if, instead of giving cod-liver oil to a child affected with rickets, he gave it a bath in the light from a quartz mercury-vapor lamp, recovery took place. In other words, the light from the lamp was the equivalent, therapeutically, of cod-liver oil. This discovery was investigated by the Vienna commission and its truth confirmed.

Now the light from a quartz mercury-vapor lamp possesses properties like those of the summer sun. It seemed, therefore, that certain animal fats are related in some way, at least so far as their influence on the human body is concerned, to solar rays, whether natural or artificial. Here, again, was a puzzle. It was known that the chemical rays, that is the violet and ultra-violet rays, cannot penetrate the skin more than the fraction of a millimetre. Could it be possible that rays which cannot pass through the thinnest skin could influence the body in much the same degree as fatty foods? Some extraordinary experiments were next carried out. One of these was to keep a number of rats in the dark and without fat. They developed rickets. But, if the floor of the cage was spread with sawdust that had been exposed to sunlight, rickets was prevented. The conclusion is obvious. Next, Professor Steenbock, of Wisconsin, discovered that many foods which did not contain animal fat could be charged with the fat-soluble vitamin by exposing them to the action of the summer sun or the quartz mercury-vapor lamp. The vitamin in question was found to be different from the growth-promoting vitamin A and also from vitamins B and C. So it was called vitamin D.

Among substances widely distributed in nature, a constituent of all animal cells and of the natural oil of the human skin, is a solid alcohol known as cholesterol. It soon developed that irradiated cholesterol, as commonly found, contained vitamin D, whereas cholesterol not so treated did not. The rationale of all the whole wonderful process is therefore this: The cholesterol of the skin may be called the pro-vitamin. The chemical rays do not shine through the skin; they shine on it, and, so doing, charge the cholesterol therein with vitamin D which thus constitutes a store upon which the body may call at any time by means of the blood circulation. However, pure cholesterol cannot store up vitamin D under the influence of light. It has been found that the important substance is an impurity commonly found in cholesterol, now known as ergosterol. As has been aptly said, ergosterol is the true "sunlight sponge."

More recently confirming this new principle, the Misses Hume and Smith, associated with Dr. S. N. Lucas, have tried the effects of inunctions of irradiated cholesterol into the skin of rats and rabbits, and found that this procedure could prevent the development of rickets. Thus, the mysterious action of sunlight is convincingly explained. To the well-known physiological action of the skin, as a protector, an organ of tactile sense, a heat regulator, and eliminator, must be added another, fully as important, namely that of absorbing and fixing the chemical rays of light, thus transforming them into a life-giving benefactor.

Ergosterol is a white crystalline substance, first isolated from ergot of rye, by the French chemist Tanret. When irradiated it becomes a pale yellowish, oily substance of extraordinary potency. A daily dose of one-hundred-millionth of a gram will produce normal calcification in a rat fed on a rickets-producing diet. The manufacture of ergosterol is now an important industry, and it is possible to incorporate measured quantities of vitamin D with various foodstuffs such as bread, biscuits, milk, butter, margarines, malt and chocolates. The summer sun of Canada or Australia can now be trapped and confined in a bottle of milk or a pat of butter, and shipped to less favored lands. The whole thing reads like a fairy tale.

Salvatore J. Parlato, M.D.: Studies of the Relative Intensity of Distribution of the Ragweed Pollen during a Period of Three

Years. (*New York State Journal of Medicine*, September 15, 1928.)

SUMMARY.—1. Studies of the ragweed pollen made in Buffalo and its vicinity during the years 1925, 1926 and 1927, have shown that the relative amount of pollen found in the air varies from one season to the other and also from day to day during the same season, depending upon the prevailing wind, the amount of rainfall and other meteorological factors.

2. There can be no fixed date as to the onset of the hay fever season because the period of time when the pollen is found in the air in sufficient quantity to produce symptoms, varies from year to year. This fact should emphasize the importance of pre-seasonal treatment, especially the perennial method as proposed and used by Aaron Brown.

3. The severity of hay fever symptoms is dependent upon the degree of the patient's hypersensitiveness and the amount of pollen which is found in the air as recorded by daily pollen counts.

4. By correlating this data, one obtains a greater insight into the activity of the ragweeds and their pollens, the biggest factor in the etiology of fall hay fever. The dosage of every injection of pollen extract for each patient can thus be more carefully calculated. In this way only, the process of hyposensitization can be made more effective and the results of our treatments prove much more satisfactory.

Edward P. McDonald, M.D. and Kenneth C. Waddell, M.D.: An epidemic of Trichinosis. (*Journal of the American Medical Association*, February 9, 1929.)

Comment.—The predominating symptoms in the series of forty-three patients were: muscle and joint pains in twenty-two; edema of the face in nine; cough in seven; severe headache in two; vomiting in two; chills in one; furuncles in one; marked hoarseness in one; lobar pneumonia in one, and bronchopneumonia in one. Eight of the patients did not present any symptoms.

The treatment should consist of rest in bed; the free administration of fluids; a high caloric diet, and 2 grains (0.13 Gm.) of mild mercurous chloride given in divided doses with a morning saline cathartic, to be repeated once after three days.

Colonic irrigations should be given together with such symptomatic treatment as may be indicated.

Clinical data should include a complete blood count; urinalysis; chemical analysis of the blood; stool and spinal fluid examinations, and biopsy of excised section of muscle.

Conclusions.—1. The majority of cases show an eosinophilia with a relatively low percentage of neutrophils and a high percentage of lymphocytes and leukosytosis.

2. In patients with a complicating infection, such as pneumonia in our series, the blood picture may be markedly altered with an absence of eosinophilia.

3. With few exceptions, cases go on to chronicity.

4. All persons who eat of trichinous pork need not necessarily give clinical evidence of the disease.

5. Although patients with cerebral symptoms and signs may show the parasites in the spinal fluid, parasites are not consistently present.

6. No known remedy is specific. Drastic catharsis early in the infection is beneficial, as it aids in ridding the intestinal tract of parasites.

7. The blood sugar was low in all patients, which may be accounted for theoretically: either because of the presence of myositis, glycogen storage was impaired, or, because of muscle involvement, sugar consumption was increased.

State Meetings

WILL state associations please notify the *Journal* immediately after settling upon the dates for annual meetings, no matter how distant? The information is requested in order that the meetings may be so scheduled that national officers and other speakers much in demand may be available for the largest possible number of organizations desiring their presence.

Industrial Nurses

THE National Organization for Public Health Nursing reported in January that approximately a 50 per cent return to the questionnaires sent out in December had been received. This is a high percentage on a first letter, showing the interest of nurses in the "Survey of Nurses in Commerce and Industry." A follow-up letter sent out in February will undoubtedly bring in an almost equal response from those who, for some reason, failed to reply to the first letter. This is an extremely important study. Even those not directly concerned with industrial nursing are eagerly waiting for the returns.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

By a number of important decisions at its January meetings, the Board of Directors of the American Nurses' Association took important steps forward in its objectives of helpfulness to the individual nurse and of professional progress. The nurse constituent received, as always, much careful thought, the problems considered being those of supply and demand in private duty, insurance, relief, a closer functioning between the national organization and the various component groups.

Registry Study.—First, perhaps, in importance was the decision to conduct a registry study through A. N. A. Headquarters. Nurse leaders believe that the registry is the greatest single factor in attacking the problem of private duty nurses and the distribution of nursing service in the community. They believe that information is needed urgently as to the various ways in which registries are being conducted throughout the country and that such information should then form the basis for further study into the functions, costs and relationships of the official registry.

The A. N. A. Board voted, therefore, that an additional member be placed on the Headquarters staff to make this registry study which is to include also the study of the relation of the registry to the distribution of nursing service.

Anagrams.—Anagrams, familiar now to a certain number of nurses in the various states, is to be discontinued. Experiments in distributing the news sheet have been tried for the past two years. At first, they were sent in bulk to the states to be distributed thence to the individual nurses. When it was found that in many instances this was unsuccessful and that those for whom the Headquarters' bulletin was especially designed were not receiving the monthly issues, this plan was given up and a new one inaugurated. Last year each state was asked to send twenty names of institutions or individuals through whom the news in *Anagrams* would be disseminated to the membership. A year's trial of this method, however, has proved beyond question that many of the states—more than half—are unable to coöperate. Regretfully, therefore, the Board voted the discontinuance of the Headquarters' news sheet, believing that the funds of the Association might bring greater returns to its membership if expended in some other way.

Relief Fund.—Significant changes were made in the administrative policy of the Nurses' Relief Fund, definitive action being required because, during the past year, the number of applicants for relief has greatly increased and demands upon the Fund have placed it in a financially precarious position. From suggestions submitted by the states and acting upon recommendations of the Relief Fund Committee, the Board of Directors at its January meetings voted:

1. That to be eligible for Relief Fund benefits, a nurse shall have practiced her profession for at least two years and immediately preceding her illness or disability.

2. That to be eligible for Relief Fund benefits, a nurse shall have been a member of the American Nurses' Association for at least two years and at the time of her illness or disability.

3. That steps be taken as soon as possible toward the establishment of a complete change of policy in the administration of relief to A. N. A. membership and that the Committee be asked to make a further study of the Relief Fund with a view to making definite recommendations to the Board as to a future policy for the administration of the Fund, which recommendations may be submitted to the membership.

4. That all beneficiaries be reviewed at least once a year and that none be automatically dropped. In carrying out this recommendation, the National Relief Fund must depend upon assistance from the local nursing groups, and it is hoped that local Relief Fund committees will have represented in their membership, nurses with some knowledge of social case work.

Harmon Plan for Annuities.—The Harmon Plan for Annuities for nurses was endorsed by the Board of Directors, and it was voted to give widespread publicity to this important plan. Information and application cards can be secured from the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, New York City. (See page 275.)

Committee Change.—Because of the close relationship between the Insurance Committee, Relief Fund Committee, and the Committee to Study the Harmon Plan, the Board voted that the Insurance Committee and the A. N. A. members of the Committee to Study the Harmon Plan, be made sub-committees of the Relief Fund Committee.

Miss Maxwell's Death.—The Board voted that a letter, expressing the great loss which the A. N. A. has suffered in the passing of Miss Maxwell, be sent the alumnae associations of Presbyterian Hospital, New York City, and of Boston City Hospital; to the Superintendent of the Presbyterian School; to the President of the Board of Directors of Presbyterian Hospital; and to Miss Maxwell's sisters. Miss Geister reported that at the time of Miss Maxwell's funeral, flowers were sent with a card representing the three national nursing organizations and the *Journal*, the inscription being prepared by Miss Carr and the lettering done by Dr. Burgess. Miss DeWitt had been appointed by the president to represent the A. N. A. at the burial in Washington. Miss Geister, Miss DeWitt, and Miss Gage had represented the nursing organizations at the funeral in New York.

Journal Dividend.—The Board of Directors of the A. N. A., as stockholders of the American Journal of Nursing Company, voted that "since a dividend can be declared, at the same time leaving a comfortable margin with which to begin the year 1929, the stockholders declare a dividend of 100 per cent of the capital stock of $8,400." This was turned over to the American Nurses' Association.

I. C. N. A sum of $700 was set aside by the Board for the necessary clerical work and other assistance which will be entailed in making arrangements for visitors as they arrive in this country and Montreal for the I. C. N. Congress in July.

Triennial.—The discussion of the relative merits of a triennial and a biennial convention received considerable discussion, following which it was voted that for the present the plan for the biennial convention be continued. It was decided further that we try to learn in 1930 what percentage of the nurses in attendance at the convention are there for the first time and what percentage have attended previous national nursing conventions. A Committee has been organized to study the administration of a convention and the possible advantages of triennial over biennial.

Finance of Grading.—Action was taken as follows with regard to the future financing of the Grading work:

1. The A. N. A. Board approved the recommendation of the Committee that quotas to complete a fund of $110,000, to be paid in three years, be assigned to the states on the basis of state membership; that proper publicity in the *American Journal of Nursing* and *Public Health Nurse* be given to these quotas, and that reprints of the publicity be secured for distribution in the states.

2. The Board went on record as believing that it is necessary to evolve some plan whereby the work of the Grading Committee, or some phases of it, may go on after the present program is completed.

3. The Board accepted the recommendation that a joint committee be created to study the definite recommendations contained in Dr. Burgess' report—although the study need not be limited to these recommendations—and that this committee report as soon as possible. The personnel of the committee will be those nurses now on the Grading Committee as the nucleus of the new group.

Revision Committee.—Decisions made by the Board relative to the questions raised by the Revision Committee were as follows:

1. As there seemed to be a need for further study, the question of Associate Membership in districts was referred back to the Revision Committee for consideration and recommendation to the Board.

2. It was the consensus of opinion that while there is no reason why the office of appointed state executive secretary and elected state secretary should not be combined in one person, the advice is generally against this practice.

Sesqui-Centennial Exhibit. The Sesqui-Centennial Exhibit is to be revivified, in part, for use by the League in June at the meetings of the International Hospital Congress in Atlantic City. The Board set aside the sum of $200 from the remaining Sesqui-Centennial Exhibit funds to make the much-used nursing

display properly presentable for this occasion, after which it will return to the care of Headquarters until such time as its ultimate fate is determined.

Ethical Standards.—A series of questions is being evolved by a Committee of Eight, these questions being such as might be presented to future committees on Ethical Standards for their consideration and for a report by them to the National Committee. It is thought by the National Committee and the Board that such questions might bring about definite standards in ethics as expressed by the nurses.

Membership Card.—One of the most interesting and important steps toward bringing closer and in more harmonious relationship the various A. N. A. groups was that taken by the Board upon recommendation of the Transfer Committee. The Committee's recommendation was adopted, to the effect that a suitable membership card be evolved, and that it be sold from Headquarters to the states, thus making possible the long-hoped-for uniform system of transfer. The card submitted by the Committee was accepted by the Board with a minor alteration in form. All but nine of the states now have the calendar year as the fiscal year—a fact that facilitates the use of a common membership card.

Sections.—A considerable discussion of the rules and regulations for Sections resulted in a vote of the Board that the Sections be asked to send to Headquarters a copy of their respective Rules and Regulations, and that the chairman of each Section be asked to come to the September meeting of the A. N. A. Board of Dirctors, provided that they are prepared to present a program of work for their respective Sections in which definite suggestions shall be included.

President's Portfolio.—The President's Portfolio, introduced at the biennial in Louisville, has proved of such value that it has been decided that copies will be furnished on a cost basis to state executive secretaries and elected state secretaries who may request a copy of this informative folio.

State Secretaries.—It was decided also by the Board that hereafter all state executive secretaries and appointed state secretaries shall receive copies of the digest of minutes and other communications issued to the states.

American Nurses' Memorial, Bordeaux School

CONTRIBUTIONS RECEIVED TO JANUARY 31, 1929

State	*Quota*	*Contributed*
Alabama	$192.40	$31.00
Arizona	55.60	....
Arkansas	160.00	....
California	2,112.00	....
Colorado	272.00	....
Connecticut	744.00	....
Delaware	60.00	60.00
District of Columbia	335.60	....
Florida	356.80	126.50
Freedman's Alumnae	24.00	....
Georgia	314.00	25.00
Hawaii	29.60	....
Idaho	33.60	....
Illinois	1,918.80	....
Indiana	490.00	....
Iowa	652.80	....
Kansas	298.00	....
Kentucky	223.20	2.00
Louisiana	405.20	....
Maine	192.80	....
Maryland	631.20	212.00
Massachusetts	1,623.20	....
Michigan	1,142.40	243.65
Minnesota	964.00	30.00
Mississippi	90.40	90.40
Missouri	987.60	....
Montana	68.40	....
Nebraska	319.60	....
Nevada	12.00	....
New Jersey	811.20	....
New Hampshire	157.60	....
New Mexico	29.20	29.20
New York	3,906.00	549.70
North Carolina	310.40	324.40
North Dakota	74.00	....
Ohio	1,708.40	1.00
Oklahoma	177.20	....
Oregon	263.60	....
Pennsylvania	2,989.20	25.00
Porto Rico	11.60	....
South Carolina	114.80	....
South Dakota	57.20	....
Tennessee	322.00	....
Texas	778.80	273.75
Rhode Island	263.20	....
Utah	79.60	....
Vermont	102.40	....
Virginia	284.00	118.00
Washington	455.20	....
West Virginia	162.00	....
Wisconsin	466.40	....
Wyoming	16.80	....
		$2,141.60

Compaign for the Grading Committee Fund—State Quotas

ON February 1, 1929, the total subscriptions received by the Nurses' Committee for Financing the Grading Plan were $54,914.90. This amount included cash contributions, payments on pledges, and pledges to be paid in the next three years.

It will be remembered that the Nurses' Committee for Financing the Grading Plan was created by the Boards of the three National Nursing Associations at a joint session in January, 1927, with instructions to raise necessary funds for the Grading Program. The Committee met in April, and after careful deliberation voted upon a program whereby requests would go to every individual nurse and every nursing association to contribute to the Grading Committee's work and share in the responsibility of raising funds. In September, 1927, the Committee launched the campaign with 70,000 letters to individual nurses and 1600 to nursing associations, and named as its objective $100,000, as the amount which it would ultimately turn over to the Grading Committee. The five-year Grading Program adopted in November, 1926, will extend to approximately the close of 1931, so that the Committee has about thirty-two months in which to complete the campaign.

At the recent January meeting of the Committee, the members unanimously agreed that plans should be developed without delay for the completion of the campaign, and that the states should be advised of the plans as soon as possible.

Several State Nursing Associations and individual nurses had suggested to the Committee that quotas would not only be acceptable but were desired by the states, so that they, in their turn, would have a goal toward which to work. Since the Grading is a national program, and its benefits are equally open to all parts of the country, the Committee, after some deliberation, voted to recommend to the Boards of the three National Associations a state quota program upon the basis of state membership in the A. N. A. and, further, that the states be asked to assume the responsibility for devising ways and means to raise their respective quotas. The National Boards approved the recommendation.

The routine administration of the campaign returns has been conducted through League Headquarters, thus reducing campaign costs to postage, stationery, and forms. To January 1, 1929, these costs were $3,021.32. The Committee in computing quotas has allowed $10,000 for intensive campaign costs and possible shrinkage, thus bringing the sum to be apportioned among the states to $110,000.

Table I shows the total subscriptions (cash receipts, payments on pledges, and pledges already made) by states to February 1, 1929. Table 2 gives state membership in the A. N. A.; states' quotas of the $110,000 fund, on the basis of 1928 membership (the 1928 membership has been employed since only part of the 1929 figures are in); the amount subscribed through individual states to February 1, 1929 (transferred from last column, Table 1); and the states' balances on their respective quotas.

Reprints of this report including tables will be sent to each State Nurses' Association as soon as available, that the State Associations may forward copies to their local nursing organizations.

When the campaign was first launched, and as the campaign has proceeded, the Committee, again and again, has been impressed by the loyal generosity and fine spirit of the response. Large contributions and small contributions have come from individual nurses and nursing groups all over this country, and frequently with the contributions, letters expressing genuine gratification for the opportunity to share tangibly in so important a professional and social undertaking. It is no small credit to the nursing profession to have raised $54,914.90 in a period of just seventeen months. The Committee begins the final stage of the campaign with complete confidence, certain that every state will meet its quota, and that some states, as Rhode Island and Wisconsin have already done, will exceed it.

CARRIE M. HALL, *Chairman*,
BLANCHE PFEFFERKORN, *Secretary*,
Nurses' Committee for Financing Grading Plan.

TABLE I—CASH RECEIPTS, PAYMENTS ON PLEDGES AND PLEDGES ALREADY MADE BY STATES TO FEBRUARY 1, 1929

States	Membership State Nurses'	Individual Nurses	Divisions A.N.A. and State Nurses' Assns. Cont. & Pledge	Dist. Assns. Cont. & Pledge	Alumnae Assns. Cont. & Pledge No.	State Leagues Cont. & Pledge No.	Local Leagues Cont. & Pledge No.	State Public Health Nurse. Assns. Cont. & Pledge No.	Visiting Nurse Assns. Cont. & Pledge No.	Student Gov. Assns. Cont. & Pledge No.	Totals

TABLE I—CASH RECEIPTS, PAYMENTS ON PLEDGES AND PLEDGES ALREADY MADE BY STATES TO FEBRUARY 1, 1929

States	Membership State Nurses' Assns.	Individual Nurses	Divisions A.N.A. and State Nurses' Assns. No.	Divisions A.N.A. and State Nurses' Assns. Cont. & Pledge	Dist. Assns. No.	Dist. Assns. Cont. & Pledge	Alumnae Assns. No.	Alumnae Assns. Cont. & Pledge	State Leagues No.	State Leagues Cont. & Pledge	Local Leagues No.	Local Leagues Cont. & Pledge	State Public Health Nurse. Assns. No.	State Public Health Nurse. Assns. Cont. & Pledge	Visiting Nurse Assns. No.	Visiting Nurse Assns. Cont. & Pledge	Student Gov. Assns. No.	Student Gov. Assns. Cont. & Pledge	Totals
			Mid-West Div. 1——$100.00 State Nurses' Assns.																$100.00
Alabama	481	$48.00	1	100.00	4	$51.50	4	$185.00											384.50
Arizona	139	13.00																	13.00
Arkansas	400	59.00	1	25.00	3	40.00							1	$5.00					129.00
California	5,280	452.40	1	50.00	15	519.00	17	845.00	1	$175.00			1	25.00					2,066.40
Colorado	680	107.10	1	50.00			6	325.00	1	50.00	1	$5.00							537.10
Connecticut	1,860	168.00	1	35.00			10	255.00									1	$5.00	463.00
Delaware	150	17.00					1	50.00											67.00
District of Columbia	839	101.00	1	100.00			3	345.00	1	50.00									596.00
Florida	892	50.00	1	35.00	2	75.00	1	10.00											170.00
Georgia	785	70.00	1	50.00	3	375.00	10	275.00	1	25.00									795.00
Idaho	84	12.00	1	25.00															37.00
Illinois	4,797	512.50	1	100.00	7	145.00	23	2,845.00	1	650.00									4,252.50
Indiana	1,225	82.00	1	100.00	2	225.00	6	146.00	1	100.00									653.00
Iowa	1,607	116.00	1	500.00	11	600.00	18	385.00	1	20.00									1,621.00
Kansas	745	49.00	1	75.00	5	450.00	3	40.00											614.00
Kentucky	558	51.00					2	50.00	1	50.00			1	10.00					161.00
Louisiana	1,013	81.10	1	500.00	5	263.00	3	145.00	1	12.50									1,001.60
Maine	482	58.00					3	50.00											108.00
Maryland	1,578	134.00	1	210.50			4	425.00					1	25.00					794.50
Massachusetts	4,058	677.60	1	1000.00	9	220.00	44	2,562.00	1	200.00									4,659.60
Michigan	2,856	241.50	1	300.00	9	545.00	9	400.00	1	125.00									1,611.50
Minnesota	2,410	168.10	1	100.00	3	850.00	20	836.00	1	125.00			1	25.00					2,104.10
Mississippi	226	21.00	1	50.00															71.00
Missouri	1,990	147.00	1	125.00	5	260.00	4	94.00	1	100.00	2	100.00							826.00
Montana	171	33.00			3	50.00													83.00
Nebraska	799	107.10	1	375.00	3	358.00	2	20.00	1	50.00	1	30.00							940.10
Nevada	30	3.00																	3.00
New Hampshire	394	43.00	1	250.00			4	85.00											378.00
New Jersey	2,028	212.00	1	500.00	4	400.00	11	460.00	1	100.00									1,672.00
New Mexico	73	10.00	1	50.00															60.00
New York	9,765	1,197.50	1	2,500.00	12	3,819.55	40	4,835.00	1	530.00	2	360.00			1	$10.00			13,252.05
North Carolina	776	83.00	1	250.00	5	260.00	4	140.00											733.00
North Dakota	185	18.00	1	50.00					1	50.00									118.00
Ohio	4,271	337.00	1	100.00	7	428.50	20	698.00							3	25.00			1,588.50
Oklahoma	443	47.00			1	25.00			1	75.00									147.00
Oregon	659	44.20	1	125.00	3	60.00	2	42.00	1	50.00			1	25.00					346.20
Pennsylvania	7,473	815.60	1	2,000.00	4	535.00	41	1,711.50	1	150.00	1	50.00							5,262.10
Rhode Island	658	78.00	1	500.00			6	475.00	1	300.00			1	125.00					1,478.00
South Carolina	287	37.00			4	45.00													82.00
South Dakota	143	19.00			1	25.00	1	5.00											49.00
Tennessee	805	37.00	1	500.00	3	315.00	2	125.00											977.00
Texas	1,947	122.05			6	130.00	2	45.00	1	25.00									322.05
Utah	199	23.10	1	125.00			2	55.00											203.10
Vermont	256	31.00	1	25.00			1	5.00											61.00
Virginia	710	99.00					3	105.00											204.00
Washington	1,138	97.00	1	125.00	9	319.00	2	75.00	1	20.00									636.00
West Virginia	405	41.00	1	125.00			1	10.00											176.00
Wisconsin	1,166	172.00			12	920.00	14	932.00	1	35.00	1	145.00	1	10.00					2,214.00
Wyoming	42	12.00			1	25.00													37.00
Foreign		57.00																	57.00
Grand totals	69,958	$7,211.85	36	$11,130.50	161	$12,333.55	349	$20,091.50	24	$3,067.50	8	$690.00	8	$250.00	4	$35.00	1	$5.00	*$54,914.90

* Total cash receipts to January 1, 1929 ..... $33,684.40
Outstanding in Pledges 21,230.50
$54,914.90

TABLE 2—STATE QUOTAS ON BASIS OF AMERICAN NURSES' ASSOCIATION MEMBERSHIP TOWARD $110,000 FUND FOR GRADING COMMITTEE

State	Membership in A. N. A.	Quota of $110,000 on Basis A. N. A. Membership	Amount Subscribed in Cash Receipts and Pledges	Balance Due on Quota
Alabama	481	$756.31	$384.50	$371.81
Arizona	139	218.56	13.00	205.56
Arkansas	400	628.95	129.00	499.95
California	5,280	8,302.12	2,066.40	6,235.72
Colorado	680	1,069.21	537.10	532.11
Connecticut	1,860	2,924.61	463.00	2,461.61
Delaware	150	235.86	67.00	168.86
District of Columbia	839	1,319.22	596.00	723.22
Florida	892	1,402.56	170.00	1,232.56
Georgia	785	1,234.31	795.00	439.31
Idaho	84	132.08	37.00	95.08
Illinois	4,797	7,542.67	4,252.50	3,290.17
Indiana	1,225	1,926.16	653.00	1,273.16
Iowa	1,607	2,526.80	1,621.00	905.80
Kansas	745	1,171.42	614.00	557.42
Kentucky	558	877.38	161.00	716.38
Louisiana	1,013	1,592.81	1,001.60	591.21
Maine	482	757.88	108.00	649.88
Maryland	1,578	2,481.20	794.50	1,686.70
Massachusetts	4,058	6,380.69	4,659.60	1,721.09
Michigan	2,856	4,490.69	1,611.50	2,879.19
Minnesota	2,410	3,789.42	2,104.10	1,685.32
Mississippi	226	355.36	71.00	284.36
Missouri	1,990	3,129.02	826.00	2,303.02
Montana	171	268.88	83.00	185.88
Nebraska	799	1,256.33	940.10	316.23
Nevada	30	47.17	3.00	44.17
New Hampshire	394	619.51	378.00	241.51
New Jersey	2,028	3,188.77	1,672.00	1,516.77
New Mexico	73	114.78	60.00	54.78
New York	9,765	15,354.21	13,252.05	2,102.16
North Carolina	776	1,220.16	733.00	487.16
North Dakota	185	290.89	118.00	172.89
Ohio	4,271	6,715.60	1,588.50	5,127.10
Oklahoma	443	696.56	147.00	549.56
Oregon	659	1,036.19	346.20	689.99
Pennsylvania	7,473	11,750.34	5,262.10	6,488.24
Rhode Island	658	1,034.62	1,478.00	
South Carolina	287	451.27	82.00	369.27
South Dakota	143	224.85	49.00	175.85
Tennessee	805	1,265.76	977.00	288.76
Texas	1,947	3,061.41	322.05	2,739.36
Utah	199	312.90	203.10	109.80
Vermont	256	402.53	61.00	341.53
Virginia	710	1,116.38	204.00	912.38
Washington	1,138	1,789.36	636.00	1,153.36
West Virginia	405	636.81	176.00	460.81
Wisconsin	1,166	1,833.39	2,214.00	
Wyoming	42	66.04	37.00	29.04
Total	69,958	$110,000.00	$54,757.90	$56,066.09

Nurses' Relief Fund

REPORT FOR JANUARY 1929

Receipts

Interest on investments $901.25

Interest on bank balance $8.94

Contributions

Alabama: District 3, $42.50; District 5, $29.50 ..... 72.00

California: State Nurses' Assn. 119.00

Colorado: St. Joseph's Hospital Alumnae Assn., $35; Glockner Alumnae Assn., $18; Bethel Alumnae Assn., $9; St. Francis Alumnae Assn., $4; St. Anthony's Alumnae Assn., Denver, $25; Weld County Alumnae Assn., Greeley, $13.50; individual contributions, Greeley, $5; individual contributions, Colorado Springs, $47 ..... 156.50

Delaware: Delaware Hospital Alumnae Assn., $12; Homeopathic Hospital Alumnae Assn., $4; Wilmington Genl. Hospital Alumnae Assn., $1; individual contribution, $19 ..... 36.00

District of Columbia: Individual contributions 22.00

Georgia: Seven members of Wesley Memorial Hospital Alumnae Assn., $7; nine members of Georgia Baptist Alumnae Assn., $9; individual contribution, $1; Margaret Wright Hospital Alumnae Assn., $5 ..... 22.00

Kansas: State Nurses' Assn. 56.00

Maine: Central District members, $42; Augusta Genl. Hospital Alumnae Assn., $5; Eastern District members, $90; Western District Assn., $20, St. Barnabas Hospital Alumnae Assn., $25 ..... 182.00

Maryland: Maryland Homeopathic Hospital Alumnae Assn. 15.00

Massachusetts: Two individual contributions, $2; Quincy Hospital Alumnae Assn., $10	12.00
Minnesota: District 2, St. Luke's Alumnae Assn., Duluth, $2; District 2 Assn., $2; individual contribution, $1; District 3, Fairview Hospital Alumnae Assn., $3; District 4, Bethesda Alumnae Assn., St. Paul, $8; individual members, $28; District 5, Immanuel Hospital Alumnae Assn., Mankato, $5	49.00
Missouri: District 2, Trinity Lutheran Hospital Alumnae Assn., $20; Kansas City Genl. Hospital Alumnae Assn., $109	129.00
Nebraska: District 2, St. Joseph's Hospital Alumnae Assn., $75; individual contributions, $26	101.00
New Hampshire: Elliot Hospital Nurses' Assn., Manchester	25.00
New Jersey: District 1, Muhlenberg Hospital, $33; Mountainside Hospital, $105; Orange Memorial Hospital, $20; individual contributions, $5; District 2, Jersey City Hospital, $51; individual contributions, $3	217.00
New York: District 2, Clifton Springs Sanatorium and Clinic School of Nursing, $25; District 4, student nurses, Hospital of the Good Shepherd, $11.50; District 7, $25; District 8, Plattsburg, Physicians' Hospital Alumnae, $25; St. Joseph's Alumnae, $40; District 13, individual contributions, $6	132.50
North Carolina: District 1, $120; District 2, $136; District 3, $20; District 4, $20; District 5, $15; District 6, $10; District 7, $10; District 8, $15; District 9, $15	361.00
Oklahoma: District 1	74.00
Pennsylvania: Graduate Nurses' Assn.	5,700.00
South Dakota: District 3	50.00
Texas: District 1, $6; District 2, $21; District 5, $36; District 13, $2; District 15, $4	69.00
Washington: State Graduate Nurses' Assn.	100.00
West Virginia: State Nurses' Assn.	100.00
Total Receipts	$8,710.19
Disbursements	
Paid to 193 applicants	$2,672.00
Postage	5.00
Salaries	254.16
Collection charge	.10
Contribution sent twice in error, returned to state chairman	27.00
	$2 958.26
Excess of income over expenditures for month ending Jan. 31, 1929	$5,751.93

All contributions to the Nurses' Relief Fund should be made payable to the Nurses' Relief Fund and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries apply to your own alumnae or district association, or to your state chairman. For leaflets and other information address the state chairman or the Director of the American Nurses' Association Headquarters, 370 Seventh Avenue, New York.

Isabel Hampton Robb Memorial Fund Committee

At the annual meeting of this Committee, held January 16, in New York, it was decided to offer seven scholarships of $300 each for 1929–1930. All applications should be in the hands of the Secretary by April 25, as the lists close on May 1.

The officers were reëlected: Chairman, Elsie M. Lawler, Baltimore; Secretary, Katharine DeWitt, New York; Treasurer, Mary M. Riddle, Muncy, Pa. Alta E. Dines was chosen a member of the Executive Committee to take Miss Maxwell's place. Laura M. Grant of Cleveland was chosen as a member of the Committee.

The Committee has suffered a great loss in the death of Miss Maxwell, who had been a member from its inception, and who was always to be relied upon to attend meetings and to do her share of the work promptly and wisely.

Isabel Hampton Robb Fund

REPORT TO FEBRUARY 12, 1929

Previously acknowledged	$33,853.62
Contributions	
California: State Association	25.00
Kentucky: Jefferson County Association	10.00
Maryland: Johns Hopkins Alumnae, Baltimore	25.00
Rhode Island: State Nurses' Association	10.00
West Virginia: State Nurses' Association	5.00
	$33,928.62

MARY M. RIDDLE, *Treasurer.*

McIsaac Loan Fund

REPORT TO FEBRUARY 12, 1929

Balance, January 9, 1929	$863.91
Bank interest, January	.38
Final payment of a loan, with interest	54.00
Contributions	
California: State Nurses' Association	25.00
Rhode Island: State Nurses' Association	10.00
West Virginia: State Nurses' Association	5.00
	$958.29
Disbursements	
None.	
Balance, February 12, 1929	$958.29

MARY M. RIDDLE, *Treasurer.*

National League of Nursing Education

Next Convention

THE next Convention of the National League of Nursing Education will be held in Atlantic City, N. J., June 17 to 21, 1929. The American Hospital Association will hold its next Convention simultaneously, including several of its allied organizations. They are very cordial in their welcome of our conference at the same time as theirs, and the two meetings will most certainly be mutually helpful. The first meeting of the International Hospital Association will take place, June 13 to 15, and many of its delegates will stay over to continue their discussions with the American Hospital Association.

Headquarters for the League will be at the Ambassador Hotel. Most of the rooms are double, at $8 and $10 a day, though there are a few single rooms at $5 and $6 a day. Meals may be obtained at the hotel, where there will be some table d'hôte menus arranged at special prices. Make your reservations as soon as possible directly with the hotel authorities.

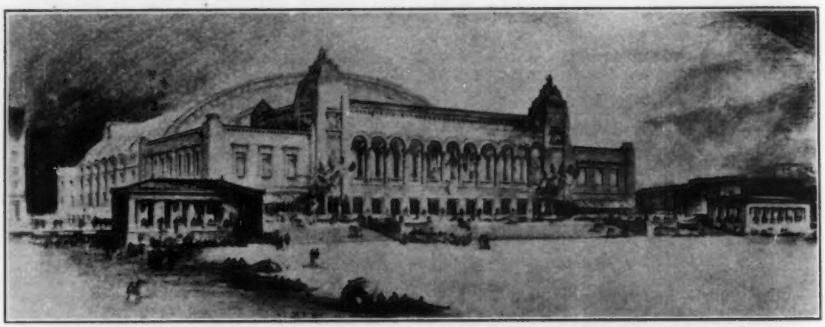
Railway rates are being arranged by the American Hospital Association and because the two Associations are meeting together of course these rates can be better than if the League were meeting alone. They can be announced as follows: the railways have agreed upon a fare and a half rate to Atlantic City for the convention period, June 13 to 22, with the return limit of ten days, with ample time for the tickets to go on sale previous to June 13, which enables anyone attending from any part of the United States or Canada to reach Atlantic City on that date.

The Ambassador, Atlantic City

Headquarters for the National League of Nursing Education, June 17–21

By the payment of fare and three-fifths, instead of fare and one-half, this return limit may be extended to thirty days, thus giving ample time for vacation in the East, if the traveler so desires.

In addition to these two rates on the certificate plan, the usual Summer rates to Atlantic City can be taken advantage of, whereby the traveler may go to Atlantic City by one route and return by another, with a time limit of ninety days or more, and with stop-over privileges both going and coming. The summer rates will go into effect on June 1, in ample time to enable the traveler to attend the Atlantic City Convention. Certificates through the American Hospital Association



Spring Will See the Completion of the World's Largest Auditorium

Now being constructed in Atlantic City, N. J. Meetings of the International Hospital Association, June 13–17, the American Hospital Association, June 17–24, and of the National League of Nursing Education, will be held under its spacious roof

BUILDING WITH ARCHED ROOF IS CONVENTION HALL
Large, light brick structure, built in two sections, in right center is Ambassador

will soon be available for distribution through local centres.

The League will have an exhibit planned to show the use by the nurse of some of the subjects taught in the Schools of Nursing. Several enthusiastic subcommittees are working hard to get attractive and convincing material to show everyone in Atlantic City why we think it necessary to teach our nurses. This exhibit should give us all more "ammunition" for our own educational endeavors. Mary Marvin of Teachers College is the chairman of the Exhibit Committee and nothing more need be said to convince us of how worth-while the work will be.

A very delightful vacation could be arranged by people from a distance, taking in the Atlantic City Convention, points of interest in the Eastern United States, or Canada, and ending with the Congress of the International Council of Nurses, July 8 to 13, in Montreal. This month would be different from the usual conventions, and give one the International flavor and interest of a trip abroad without the expense. Communicate with Caroline Garnsey, 370 Seventh Avenue, New York, National Transportation Chairman, for the Congress of the International Council of Nurses as announced in the January *Journal*. She is arranging many suggestive and attractive trips and will be glad to tell about them.

We hope for a large number of people at Atlantic City so that we can talk over the important things before our profession today, and also embrace the opportunity to meet the International and American Hospital Association delegates whom usually we miss.

OUTLINE OF LEAGUE PROGRAM

Following are the main topics. The speakers will be given an opportunity to formulate their own titles so long as they cover the desired topic. (1) Principles of Administration. (2) Interprofessional Relationships. (3) Ethics of Employment: (a) From the standpoint of the employer; (b) from the stantpoint of the employee. (4) New Principles of Personnel Management. (5) Development of Better Postgraduate Courses. (6) Mental Hygiene for Student Nurses. (7) Correlation of Theory and Practice.

Montreal and the International Council of Nurses

THE president of the Council has just returned from a short visit to Montreal to discuss certain plans for the forthcoming Congress to meet next July. Arrangements are going forward rapidly, and everyone who goes will have a delightful time. The Canadian Nurses' Association has some very attractive festivities in mind, and committees are working hard to make us happy, and give us a chance to profit by the program. The high school to be used for headquarters is very large and commodious, and can have several rest and writing rooms, in addition to committee rooms and auditoriums. There is a swimming pool in the basement, so that one can be well refreshed after meetings and study of the exhibits. The hotels are all near headquarters, so that there will not be long walks on hot days. Parking facilities for cars will be available.

Send requests for reservations, early in March, to Miss M. F. Hersey, Royal Victoria Hospital. Give her details as to your choice of a roommate, what branch of nursing now engages your attention, and whether you will arrive by train or in a car. She can then arrange for you to be as comfortable as possible, and she will have some idea of the number of cars needing parking space. For convenience and speed in crossing the border, have some identification papers with you, such as a birth certificate to prove your citizenship; your state registration card; and some membership card in your nursing organization. These will often not be needed, but may, at times, save weary waiting.

How to procure travel certificates and railway rates will be announced later. Watch the *Journal* for details.

There will be a charming, quaint, international flavor to Montreal, and we are fortunate indeed to have the Canadians as our hostesses, and to be able to help them entertain the foreign guests.

NINA D. GAGE.

HOUSING

Many nurses expecting to attend the meetings of the I. C. N. have been writing for single rooms, the supply of which is now exhausted in the large hotels, although such rooms can be supplied in private homes and in boarding houses and, to a limited extent, in the smaller hotels. When the date for the meeting of the I. C. N. was set for the 8th of July, Montreal nurses realized that housing in the hotels would be a real problem due to the fact that the tourist season begins about July 1 and the annual number of visitors to Montreal in the summer taxes the hotels to their capacity. However, the hotel managers when interviewed said they would reserve as many beds as possible in their hotels for nurses attending the Convention on the understanding that nurses would share rooms, going two, three or four to a room. On this understanding, rooms are still available in the following large hotels at these rates:

Mount Royal Hotel (all rooms have baths)—Two in a room, $7 per day; three in a room, $9 per day; four in a room, $10 per day.

Windsor Hotel—Two in a room with bath, $8, $9, $10 per day; two in a room without bath, $6 per day; three in a room with bath, $10.50 per day; three in a room without bath, $8.25 per day; four in a room with bath, $12 per day; four in a room without bath, $10 per day.

Place Viger Hotel—Three in a room with bath, $9 per day; three in a room without bath, $7.50 per day; four in a room with bath, $10 per day; four in a room without bath, $8 per day.

N. B.—Rates quoted above are for the room and not per person.

Rooms will be available in private homes and in boarding houses at the rate of from $1.50 to $2 per night, per person. Rooms in small hotels will be about $2 to $2.50 per night, per person.

Convents will be able to take care of quite a large number of nurses at from $1.25 to $2 per night per person, including breakfast at prices quoted. Accomodations will be either beds in dormitories or double rooms. The Y. W. C. A. has rooms at the same rates as the Convents.

Nurses coming in autos will find ample parking space.

EDITH B. HURLEY,
Convenor Housing Committee, I. C. N.

Notice.—It is necessary that all data concerning the names, addresses and official positions of all nurses planning to attend the Congress shall be filed at Headquarters in Montreal. Such information should be sent to the Executive Secretary Arrangements Committee, Royal Victoria Hospital, Montreal, by the nurses, themselves, as early as possible.

E. FRANCES UPTON,
Executive Secretary.

Headquarters.—The Montreal High School, University Street, Montreal.

Registration.—The registration bureau will be at headquarters. Registration will begin

on July 5 and continue throughout the following week.

Restaurants.—Information regarding restaurants will be available at headquarters. Meals outside hotels need not cost more than 50 cents to 75 cents for breakfast, 75 cents for lunch and $1 for dinner.

Program.—The Convenor of the Program Committee has announced that a program will soon be ready for publication.

Exhibits.—It is considered advisable that all exhibits should be in Montreal not later than May 15. It will be a great help to the Exhibits Committee if all cases are clearly marked for the section to which they belong, viz., Nursing Education, Public Health, etc. An inventory of the contents and instructions regarding their arrangement should be enclosed with the exhibits. The exhibit room is to the left of the main entrance to headquarters and can also be entered from the street. The committee hopes to meet all requests for space and urges exhibitors to state clearly the amount of space desired when making application. Address applications to Miss C. M. Ferguson, Convenor of Exhibits Committee, Royal Victoria Hospital, Montreal, before April 1.

Social Affairs.—Arrangements are not completed but those already planned include a visit to Ottawa and a reception at Government House for the Grand Council, and a garden party on the last day of the Congress for the entire Congress membership.

Meeting Places.—The Forum will be used for the large General Sessions. The Montreal High School will be used for meetings of the Nursing Education Section and rooms will be reserved here for special meetings of nurses from affiliated countries. The Mount Royal Hotel will be the meeting place for the Public Health Section. The Windsor Hotel will be the meeting place for the Private Duty Section.

Information.—An Information Booth will be maintained at Headquarters and will be open every day until 11 p. m.

A list of Convention members will be available for nurses wishing to locate friends.

Side Trips of Interest.—Information regarding interesting places in and near Montreal will be placed in the folder given to each nurse on registration.

Transportation

Convention rates of fare and one-half will be authorized on the *Identification* Certificate Plan. Tickets may also be sold for this Convention on the basis of fare and three-fifths with final return limit of thirty days. The round trip tickets will be sold at the starting point. For some sections the usual summer rates may be less expensive. Consult local ticket agent for comparative prices. All nurses should reach Montreal by the morning of Monday, July 8, as the first meeting is at 2 p. m.

Caroline Garnsey, Executive Secretary of the New York State Nurses' Association, 370 Seventh Avenue, New York, has been appointed National Chairman. The following regional representatives have been appointed and all local transportation arrangements will be made through them:

North Eastern States: New England, New York, New Jersey, Delaware, Pennsylvania, Maryland, District of Columbia. Chairman, Marietta B. Squire, 105 S. Grove Street, East Orange, N. J. Sub-Chairman for Washington, D. C., Annabelle Peterson, 1337 K. Street, N. W., Washington, D. C.; for Maryland and Delaware, Sarah F. Martin, 1211 Cathedral Street, Baltimore, Md.; New York, Grace B. Hinckley, Methodist Episcopal Hospital, Brooklyn, N. Y. New Jersey, Arabella Creech, 42 Bleeker St., Newark, N. J.; Pennsylvania, Esther A. Entriken, 400 N. 3rd St., Harrisburg, Pa.

For District of Columbia and Maryland to New York City, the Baltimore and Ohio Railroad. From New York City to Montreal, the New York Central and Delaware and Hudson Railroads will operate special trains, leaving New York 9.30 p. m. from the Grand Central Terminal, and arriving in Montreal 7.30 a. m. at the Windsor Station.

South Atlantic States: Florida, Georgia, North Carolina, South Carolina, Virginia, West Virginia. Chairman, Martha V. Baylor, Roanoke Hospital, Roanoke, Va.

West Coast States: Washington, Oregon, Idaho, Nevada, California. Chairman, Anna C. Jammé 609 Sutter Street, San Francisco, Calif.

Mountain States: Montana, Wyoming, Utah, Arizona, Colorado, New Mexico. Chairman, Loretta Mulherin, St. Joseph's Hospital, Denver, Colo.; Sub-Chairman for Montana, Frances Friederichs, Helena, Mont.; for Arizona, Catherine O. Beagin, Clifton, Ariz.

For Colorado, Utah, Wyoming, the Union Pacific Railroad and the Canadian Pacific Railroad. For Arizona, New Mexico, the Sante Fe Railroad to Chicago.

South Central States: Missouri, Kansas, Oklahoma, Texas. Chairman, Ada Louise Deitrich, 1001 Nevada Street, El Paso, Texas.

North Central States: Minnesota, Ohio, Iowa, Nebraska, Illinois, Wisconsin, North Dakota, South Dakota, Indiana, Michigan.

Chairman, May Kennedy, 6400 Irving Park Blvd. Chicago, Ill.

Canadian National Railroad will be used.

Gulf States: Tennessee, Arkansas, Louisiana, Mississippi, Alabama, Kentucky. Chairman, Mrs. B. S. Cawthone, Bureau of Public Health, City Health Department, Memphis, Tenn.

Hawaii: Chairman, Mrs. J. T. Wayson, 2828 Kahawai Street, Honolulu, Hawaii.

Porto Rico: Chairman, Mrs. Erudina A. Crespo, Box 362, San Juan, Porto Rico.

For information relative to trips abroad following the Convention, or special trips in this country for visiting nurses from abroad, write the National Chairman.

Middle Atlantic Division

THE Middle Atlantic Division of the American Nurses' Association will hold its next meeting in Philadelphia, April 25 and 26, and the headquarters for the meeting will be at the Bellevue-Stratford Hotel, Broad and Walnut Streets.

The Mid-West Division

THE meeting of the Mid-West Division of the American Nurses' Association will be held in Detroit, April 12 and 13, at the Book-Cadillac Hotel.

The program has been built around nursing problems common to the five states which make up the division. The registration laws, basis for transfers within the states, registeries for nurses, and educational facilities open to the nurse who lives in the Middle West, will be subjects for discussion.

The names of Adda Eldredge, Mrs. Mabel Scott Huggins, Ellen Atchison, Erma Kowalke, are listed as presiding at group luncheons at which bedside nursing, health education, and the principles of supervision will be discussed. A Red Cross luncheon with Mrs. Elsbeth H. Vaughan in charge will have Dr. Wm. De Kleine as speaker. Mrs. Hugo A. Freund, president of the board of directors of the Detroit Visiting Nurses' Association will preside at a luncheon for lay persons.

For the first general session on Friday, April 12, Dr. May Ayres Burgess will speak on "Nursing Economics." This talk will be discussed by a prominent layman, a physician, and a nurse.

Dr. Reinhold Neibuhr of Union Theological Seminary, New York City, has chosen "World Peace" as his subject for the general session of Saturday, April 13.

Mabel Dunlap of Illinois is president of the Mid-West Division.

New England Division

THE biennial meeting of the New England Division, American Nurses' Association, will be held at Hotel Taft, New Haven, Conn., on April 11, 12 and 13, 1929.

The program will include: "Mental Hygiene," Dr. George Pratt, National Committee for Mental Hygiene; "Mental Disease in Relation to the Function of Digestion," Dr. Horace K. Richardson, Towson, Md.; "Whither Nursing," Elizabeth G. Fox, Director of Public Health Nursing Service, American Red Cross; "Relation of Boards of Managers to Nursing Schools and Organizations," Annie W. Goodrich, Dean, Yale School of Nursing; "The Relation of the Nurse to Her Profession and to the Community," Dr. C.-E. A. Winslow, Professor of Public Health, Yale University; "Occupational Therapy," Dr. O. G. Wiedman, Hartford, Conn.; "Red Cross Activities," Clara D. Noyes, Director of Nursing Service, American Red Cross.

Luncheon Discussions, "Intelligence Tests and Selection of Students," "How can the Small Hospital Function as a Health Center?" "The Function of the Registry in the Community," "Policies of Organizations regarding Progressive Education for Their Staff," "Opportunities for Progressive Education."

Southern Division

THE dates of the Southern Division Conference are October 28, 29, 30. It will be held in Birmingham, Ala. Helen McLean is chairman of the Arrangements Committee.

Army Nurse Corps

During the month of February, 1929, orders were requested for the transfer of the following named members of the Army Nurse Corps to the stations indicated: to William Beaumont General Hospital, El Paso, Texas, 1st Lieut. Maude C. Davison, 2nd Lieuts. Josephine E. Heffernan, Etta M. Staub; to Fort Benning, Ga., 2nd Lieut. Ruth C. Anderson; to Fitzsimons General Hospital, Denver, Colo., 2nd Lieut. Anna D. Wight; to Letterman General Hospital, San Francisco, Calif., Louise S. Heyen,

Phoebe Nelson, Bertha Appleman, Ella Huey, Margaret McM. Bell, Edna D. Umbach, Elizabeth A. Hagerty, Katharine V. Young; to Fort Sheridan, Ill., 2nd Lieuts. Caroline M. Myers, Karoline E. Nilson; to Fort Sill, Okla., 2nd Lieut. Cornelia W. Heiss; to Walter Reed General Hospital, Washington, D. C., 2nd Lieuts. Ella G. Neff, Caroline K. Struck, Minnie M. Black; to West Point, N. Y., 1st Lieut. Lillian J. Ryan; to Hawaiian Dept., 2nd Lieuts. Margaret M. Hennessey, Kathryn M. Morgan; to Philippine Dept., 2nd Lieuts. Laura K. Wood, Clara J. Perry, Mina A. Aasen, Helga C. C. Borg; to San Juan, P. R., 2nd Lieut. Clara L. Bemis.

Ten have been admitted to the Corps as Second Lieutenants.

The following named are under orders for separation from the Corps: Christine Cornell, Kathleen T. Royer, Lois O. Mohler, Elsie A. Hopman, Katherine S. King, Emily M. Hanson, Blanche E. Wheatley, Lewis Ellis, Carrye A. Rice, Lillian C. Brown.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

Transfers: To Annapolis, Md., Gertrude Sachs; to Chelsea, Mass., Olga H. Beutenmiller, Tena M. Wolken, Ethel R. Parsons; to Canacao, P. I., Florence M. Field; to Guam, M. I., Marguerite Rea; to League Island, Pa., Eva B. Moss, Chief Nurse, Rose M. Culbertson; to Newport, R. I., Thomasina Libby, Margaret M. Redmond; to New York, N. Y., Laura M. Cobb; to Pearl Harbor, T. H., Adele Scudder; to Quantico, Va., Anna E. Caveney; to San Diego, Calif., Louise Madsen, Anna A. Reimers; to Washington, D. C., Margaret B. Brewer.

The following nurses were separated from the Service: Della V. Singleton, Eleanor T. Hillegass, Emma E. Long, Gladys C. Martin, Mary E. Weston, Barbara F. Egenrieder.

J. BEATRICE BOWMAN,
Supt., Navy Nurse Corps.

U. S. Public Health Service

Transfers: To Portland, Maine, Alice Nerney; to Port Townsend, Wash., Laura Zwanzig; to Louisville, Ky., Ethel Friedman; to New Orleans, La., Ina Louise Crawford; to Key West, Fla., Winnie Stinson; to Memphis, Tenn., Claire Hurley; to Norfolk, Va., Blanche Culbertson; to Stapleton, N. Y., Susan Rudden; to Philadelphia, Pa., Ruth Moyer; to Hudson St., New York, Katherine Shields.

Reinstatements Bertha Perry Butler, Mary Morgan, Florence Armitstead, Josephine Taylor, Bernice Guthrie, Bennetta Tobin, Thelma Burns, Gwendoline Fatherree, Alice Jordan, Florence Rooney, Anastasia Clark.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

REPORT OF NURSING SERVICE FOR JANUARY

Separations: Twenty-three.

Assignments (new): Thirty.

Reinstatements: Elizabeth Wabaunsee, Clara Hayes, Gertrude Bastis, Dorothy Schaffer, Abby Lee, Marguerite Brueshaber.

Transfers: Mary Culbertson, Chief Nurse, to Fargo, N. D.; Bessie Moore, Cecilia Hermsen, Mary Hall, Emma Mommson, Lulu Wilkins, Sara Xavier, Elizabeth Blakistone, Dora Roller, to Portland, Ore.; Lillian Van Der Weyden, Mattie Harrison, to Maywood, Ill.; Elizabeth Nelson, Annie Higbie, to Washington, D. C.; Angie Darrow, to Castle Point, N. Y.; Margaret Cunningham, to Fort Harrison, Mont.; Myrtle Thompson, to Minneapolis, Minn.; Annette Snodgrass, to Whipple, Ariz.; Mary Scarborough, to Dwight, Ill.; Rose Crawford, to Gulfport, Miss.

MARY A. HICKEY,
Supt., of Nurses, U. S. V. B.

U. S. Indian Service

Resignations: two.

Transfers: Mrs. I. Pearl Clarke to Klamath, Oregon.

Appointments: six.

ELINOR D. GREGG,
Supervisor of Nurses.

United States Civil Service Examinations

The United States Civil Service Commission announces an open competitive examination for the positions of graduate nurse, graduate nurse (visiting duty) and graduate nurse (junior grade). Vacancies in the Departmental Service, Washington, D. C., in the United States Veterans' Bureau, and in the Indian and Public Health Service, and in positions requiring similar qualifications, will be

filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

Prerequisites: General requirement.—For any of these positions applicants must have been graduated from a four years' high-school course or have completed 14 units of high-school work acceptable for college entrance; provided, that those who are otherwise qualified but who do not meet this requirement will be given a noncompetitive mental test in lieu thereof which will require one hour and fifteen minutes, and in which nonpreference applicants must attain a rating of at least 50, applicants entitled to military preference a rating of at least 45, exclusive of military preference credit, and applicants entitled to disability preference a rating of at least 40, exclusive of military preference credit. Applicants for whom this test is required will be notified of the date and place thereof.

Applications for the positions named above must be on file with the Civil Service Commission at Washington, D. C., not later than June 29.

Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or from the Secretary of the United States Civil Service Board of Examiners at the post office or custom-house in any city.

Institutes and Special Courses

Iowa: The IOWA LEAGUE OF NURSING EDUCATION is arranging for a two-day institute, April 19–20, to be held at University Hospital, Iowa City.

State Boards of Examiners

Georgia: Examination for graduate nurses will be held April 10–11, 1929, in Atlanta, Augusta, Macon and Savannah, provided a sufficient number of applications are received.

Graduate nurses should apply immediately to the Secretary of the State Board of Examiners of Nurses, 131 Forrest Avenue, N. E., Suite 18, Atlanta, and secure a temporary permit to practice, since it is illegal for such nurses to practice without license in Georgia.

Iowa: The regular quarterly examination for graduate nurses will be held at the State House, Des Moines, April 25–27, 1929.

Kentucky: An examination for graduate nurses will be conducted by the KENTUCKY BOARD OF NURSE EXAMINERS, in Louisville, on the 21st and 22d days of May, 1929. All necessary information and applications may be secured by writing to Flora E. Keen, Secretary, Thierman Apt. C–4. Louisville.

Louisiana: The next examination of the LOUISIANA NURSES BOARD OF EXAMINERS will be held in New Orleans and in Shreveport, May 1 and 2, 1929. For further information, address Julie C. Tebo, Secretary, 1005 Pere Marquette Building, New Orleans.

Maine: The STATE OF MAINE BOARD OF REGISTRATION AND EXAMINATION OF NURSES will hold an examination for applicants for registration the third Wednesday in April, also Thursday, being April 17 and 18, 1929, beginning at 9 A. M. at the State House, Augusta. Applications must be filed with the Secretary, Theresa R. Anderson, Box 328, Bangor, fifteen days previous to date of examination.

North Carolina: The NORTH CAROLINA BOARD OF NURSE EXAMINERS will give examinations, April 24–26, in the House of Representatives, Raleigh. All applications must be filed with the Secretary by April 10. Applications may be procured from the Secretary, Mrs. Z. V. Conyers, Greensboro.

Oregon: The OREGON STATE BOARD FOR EXAMINATION AND REGISTRATION OF NURSES will conduct an examination for applicants desiring to register, in Portland, April 25 and 26. No applications will be accepted after the 15th of April. For further information write Grace L. Taylor, Secretary, 448 Center Street, Salem.

Pennsylvania: The PENNSYLVANIA STATE BOARD OF EXAMINERS FOR REGISTRATION OF NURSES will conduct examinations on Saturday, March 16, in Philadelphia, Pittsburgh and Wilkes-Barre. Applications should be filed before March 1 with Mrs. Helene S. Herrmann, Secretary-treasurer, 812 Mechanics Trust Building, Harrisburg.

West Virginia: The WEST VIRGINIA STATE BOARD OF EXAMINERS FOR REGISTERED NURSES will hold an examination for registration on Monday, April 15, 1929, at the Ohio Valley General Hospital, Wheeling, W. Va., and at the new Charleston General Hospital, Charleston. Mrs. Andrew Wilson, Secretary-treasurer, 1300 Byron Street, Wheeling.

The other members of the Examining Board are: Frank LeMoyne Hupp, M.D., President, Harriet B. Jones, M.D., Vesta V. Reid, Mrs. N. McIntosh Noel, Mabel C. Fuller.

State Associations

Arizona: The STATE NURSES' ASSOCIATION will hold its annual meeting in Phoenix, some time in April.

Colorado: The COLORADO STATE GRADUATE NURSES' ASSOCIATION held its annual meeting at the Brown Palace Hotel, in Denver, February 5–7. The address of welcome was given on Tuesday evening by Lieutenant Governor George Corlett of Colorado. Musical numbers were given during the evening by a student chorus made up of representatives from all of the schools of nursing in Denver.

After the business meeting of the State Association, the program was turned over on Wednesday to the State League of Nursing Education. One of the most interesting speakers on this program was Dora Cornelisen, Field Representative for the *American Journal of Nursing*, who talked on the *Journal* and its uses. Wednesday evening, at the Brown Palace Hotel, one hundred and ninety nurses attended the annual banquet to celebrate the twenty-fifth anniversary of the Colorado State Graduate Nurses' Association.

Thursday morning was given over to the Public Health Section and to a round-table discussion for State Board members and those interested in nursing education. The Alumnae luncheon was followed by the Private Duty Section, whose entire time was spent in the discussion of "Nurses, Patients and Pocketbooks." The remainder of the afternoon was spent on unfinished business and the report of the tellers. The following officers were elected: President, Ann Dickie Boyd; vice presidents, Ruth Colestock, Ellen Perdue; secretary, Irene Murchison; treasurer, Lela Underhill; counselors, Mrs. Oca Cushman, Loretto Mulherin.

Connecticut: The twenty-fifth annual meeting of the GRADUATE NURSES' ASSOCIATION was held in Hartford at the Hotel Bond, February 6, 7 and 8. The first day was given over to the program of the Educational Section. At the morning round table, Gertrude Hodgman, Assistant Professor of Nursing, Yale University School of Nursing, gave a splendid talk on "How Can We Further the Education of the Nursing Staff?" Following the talk there was general discussion. At the afternoon session a report of the Nursing Institute given in Hartford in November, 1928, was made by Eunice Smith, Chairman of the Educational Committee. Miss Smith reported that over 500 registered during the three days of the Institute. This was followed by an address by Dr. Martha Elliott on "Child Hygiene during the Pre-school Years." Professor Isabel Stewart, of Teachers College, spoke on "A Coöperative Experiment in the Preparation of Head Nurses."

At the evening session Janet Geister, Director at A. N. A. Headquarters, was the principal speaker, whose subject was, "What Can I Do About Nursing Problems?" Miss Geister's talk was excellent, and gave everyone there much to think about.

Thursday was given over to the Public Health Nursing Section and the Private Duty Section. The Public Health Section for its morning meeting had William B. Bailey, Economist at the Travelers' Insurance Company, who gave a splendid talk on "The Relation between Public Health and Life Insurance." The afternoon session was a joint meeting between the Board Members' Division and the nurses. Mrs. Mary Swain Routzahn of the Russell Sage Foundation spoke on "What Our Supporters Should Be Told about Our Work." This was a splendid talk and gave the Board members and nurses much needed information. The Board Members' Division held their meeting in the morning, and the speaker was Lillian Pruden, former President of the New Haven Visiting Nurse Association, who spoke on the Board Members' Manual. The Private Duty Section had for its speaker Dr. Otto G. Weidman, President of the Connecticut Occupational Therapy Society. In the afternoon at a round table where official registries were discussed, the speaker was Mrs. Angelia Lenz, Registrar of the New Haven Central Registry.

The Friday morning session was given over to the business meeting of the State Association. In the afternoon a talk was given by Edith Valet Cook of New Haven on "A Survey of State Institutions."

Each day tea was served. The first day by the Visiting Nurse Association at its office; the second day at the Hotel Bond by St. Francis Hospital Alumnae Association; and the third day at the Heublein Hall, in the nurses' residence at the Hartford Hospital, by the Hartford Hospital Training School Alumnae.

Thursday night was given over to social activities when the banquet of the State Association was held. It was different from other banquets, in that only members and invited guests were present, and it was the silver anniversary. The members were happy to have six of their charter members present, and letters were received from many who were unable to be there. A ten-minute history of the State Association was read by Miss Bigelow, following which a silver loving cup

was presented to the State Association, the gift of the International Silver Company of Meriden. Following this, a birthday cake with 25 candles was brought to the table where the charter members were sitting. Between the courses the group joined in songs. St. Francis Hospital nurses gave musical selections following the dinner, and the Dramatic Club of Hartford Hospital put on a one-act play, "Thank You, Doctor." It was the opinion of those present that the banquet was the best ever, and it made everyone realize, as never before, that the charter members had vision, the benefits of which all are getting today. A mimeographed *Daily Bulletin* was published each day for the benefit of the members. The total registration for the three days was 475.

The following officers were elected: Graduate Nurses' Association—President, Margaret J. Barrett, New Haven; vice presidents, Irene V. Muller, Hartford, Katherine Odell, Elmwood, Norma White, New Haven; secretary, A. Lillian Forbush, Middletown; treasurer, Mabel Macdonell, Stamford; two directors, Mrs. Winifred Bramann, Louise B. Johnson. Educational section—Chairman, Rachel McConnell, Hartford; vice chairman, Mrs. Winifred Hart, Bridgeport; secretary, Maud E. Traver, New Britain; director, Effie J. Taylor, New Haven. Public Health Nursing Section—Chairman, Louise C. Spence, Bridgeport; vice chairman, Mabel Macdonell, Stamford; secretary, Ethel R. Biggs, East Hartford; councillors, Harriet Parker, Grace Platt, Mary Grace Hills, Marjory Webster, Sarah Ure. Private Duty Section—Chairman, Gladys Pease, Hartford; secretary, Mrs. Angelia Lenz, New Haven.

Delaware: The annual meeting of the DELAWARE STATE ASSOCIATION OF GRADUATE NURSES was held January 24, at the Delaware Hospital, Wilmington. The business meeting was held in the afternoon. Amendments for the constitution and by-laws were made. Election of officers was held, with the following result: President, Evelyn Hayes; vice presidents, Mrs. Helen Wiseheart, Amelia Kornbau; secretary, Mrs. Mae P. Smith; treasurer, Tacie Matthews; directors, Florence Marvel, Mrs. Allen Speakman. A box supper was served, followed by a social program in the evening. Dr. Roscoe Teahan, Medical Director of Jeannes Hospital, Fox Chase, Pa., an authority on cancer, was the speaker of the evening, and gave a most interesting talk on "Cancer." He recommended yearly health examinations in order to give the physician opportunity for early diagnosis and treatment, and thus decrease the spread of cancer.

Maryland: The annual meeting of the MARYLAND STATE NURSES' ASSOCIATION, in joint session with the Maryland League of Nursing Education and the Maryland State Association for Public Health Nursing, was held in Baltimore, January 29–31. An appeal for a good attendance was sent out with the programs, and the meetings were well attended.

The meetings on Tuesday were held under the auspices of the Maryland State Nurses' Association, Jane E. Nash, President, presiding. Rev. Roger A. Walke, Rector St. Mark's on the Hill, opened the meeting with prayer followed by a short address. Miss Nash, in her annual address, said: "The next few years will see many adjustments in the nursing situation, both as to schools of nursing and the registered nurse. There is no reason to be anything but optimistic about the future of nursing. It is a great profession with great leaders, and when the present intensive study is completed and all the facts and opinions are carefully weighed the profession will emerge much better qualified to do its great work in the world, which is primarily to assist in the prevention and cure of disease." At the business meeting the Secretary's report showed an increase of membership, and also stated that over $400 toward Maryland's quota of $631.20 had been contributed for the Florence Nightingale School of Nursing at Bordeaux.

On Tuesday afternoon, members had the great pleasure of having as the speaker, Ida F. Butler, Assistant National Director Red Cross Nursing Service, whose subject was "The American Red Cross and the Nurse." Students were invited to this session, and they manifested much interest. Miss Butler was entertained at a luncheon given by Miss Nash at the Church Home, and the members of the Maryland State and Local Committees of the Red Cross Nursing Service, with the officers of the State Nursing Organizations, were also guests. After the afternoon meeting tea was served by the St. Barnabas Guild.

The speaker at the evening session was Dr. Allan K. Krause, Director, Tuberculosis Clinic, Johns Hopkins Hospital.

On Wednesday the meetings were held under the auspices of the Maryland League of Nursing Education, Alice Lloyd Winder, First Vice President, presiding. The morning and afternoon sessions were held at the Johns Hopkins Hospital. Nurses from several of the Baltimore hospitals gave practical demonstrations of nursing procedures, and at the

morning session the speakers were: Dr. Esther L. Richards, Johns Hopkins Hospital, and Agnes Snyder, Director, City Practice Teaching. After the afternoon session Miss Lawler and her staff entertained at tea.

The evening session was held at Osler Hall, with Mary M. Roberts as the speaker. Miss Roberts was given a warm welcome by the Maryland nurses, who have every reason to hope that her inspiring address will not only yield fruit along many lines, but will also increase the number of subscriptions to the *American Journal of Nursing* in Maryland.

On Thursday, the meetings were held under the auspices of the Maryland State Association for Public Health Nursing, Mrs. Ethel Monroe Troy, President, presiding. The morning session was held at the University Hospital, when the physicians on the hospital staff spoke on their particular lines of service. At this session several reels of films were shown, showing among other subjects the rural nurses at work in their different fields of public health work.

Lunch was served after the morning session by the officers of the University Hospital. At the afternoon session, Mrs. Page Edmunds, President, Women's Civic League, was the speaker who took as her subject, "Baltimore, Old and New," which was accompanied with motion pictures. Mrs. Edmunds is a graduate of the University Hospital Training School for Nurses, and the nurses gave her a hearty welcome.

The annual meeting closed with a dinner of the State Nursing Organizations at the Lord Baltimore Hotel, and was well attended. Mrs. Ethel Monroe Troy presided, and the speakers included Dr. Lillian Welsh, Jane E. Nash, Mary M. Roberts, Dr. Mary Sherwood, and Theodore B. McKeldin, Secretary to the Mayor of Baltimore.

Michigan: The MICHIGAN STATE NURSES' ASSOCIATION will hold its annual meeting at the Book-Cadillac Hotel, Detroit, April 11, preceding the meetings of the Mid-West Division. The program for the State meeting is: Wednesday, April 10, 7.30 p. m., Board of Directors. Thursday, April 11, 9 a. m., registration. 10 a. m., business session, Emilie Sargent, President, presiding. Reports of committees; new business. 12.30–2 p. m., business luncheons of the Michigan League of Nursing Education, the Private Duty Section, and the Public Health Section. The business session will be continued in the afternoon. At 6.30 p. m. there will be a 25th anniversary dinner, Miss Sargent presiding. Mrs. L. E. Gretter will give a history of the State Association, illustrated with slides, and there will be an address by Sarah E. Sly.

Ten districts were represented at the Board meeting of the MICHIGAN STATE NURSES' ASSOCIATION, which was held in Lansing, January 30, at the Olds Hotel. The members of the Board offered to assist in arousing public interest in the additional funds which the Michigan Department of Health is asking from the legislature to carry on its child hygiene program after Sheppard-Towner funds are withdrawn.

Nevada: At a recent meeting of the NEVADA STATE NURSES' ASSOCIATION, the following officers were chosen to serve for the year 1929: President, Mrs. Edith Alden; secretary, Claire Souchereau; treasurer, Mary Evans, all of Reno.

Ohio: Tentative program of the 25th anniversary convention of the OHIO STATE NURSES' ASSOCIATION, to be held at the Hotel Sinton, Cincinnati, April 10–13.

Wednesday, April 10, 3 p. m., Board of Trustees; 8 p. m., Advisory Council; 8.30 p. m., informal reception.

Thursday, April 11, 9.30 a. m., business meetings of Sections, Nursing Education, Private Duty, Public Health. 10, opening session, Clara F. Brouse presiding. Invocation, address of welcome, response, President's address, business and reports. 1.30 p. m., business session continued. Addresses on the *American Journal of Nursing* and on "Insurance." 4.30, round tables for registrars and registry committees. 8 p. m., historical review—pageant.

Friday, April 12, 8–10 a. m., round tables. Section on nursing Education, Problems in Teaching: Record keeping as applied to clinical experience, Record keeping as applied to theory, The health of the student nurse. Section on Public Health Nursing, The content of a nurses' visit to a tuberculosis patient, Relation of industrial nursing to public health nursing, The work of a nurse in physical examinations of school children and the duties of a school nurse in general. Section on Private Duty Nursing, When and by whom was hourly nursing started? Hourly nursing today. How can one establish hourly nursing? What can a nurse do to finance herself until established? How are calls cared for in the absence of the nurse? Which makes the best nurse for hourly nursing—private duty or public health nurse? Section on Nursing Education, Hospital Problems: Developing friendliness between students of local schools, Local conferences of principals, Training for graduate responsibility, The central dressing

room, Scholarships for student nurses (interesting boards of trustees), Specific preparation for head nurses. 10.15, address, "Staff Education," paper, "The Head Nurse." 1.30 p. m., addresses on "Social Hygiene," "Health of the American Child," "History of Public Health Nursing in Ohio." 4.30 p. m., round table for officers. Red Cross Committee. 7.30 p. m., annual subscription banquet with an address.

Saturday, April 13, 9 a. m., "Selection of Students for Accredited Schools of Nursing," "Legal Aspects of Drugs": (a) Changing labels, (b) Responsibility of hospital for errors in dosage or drugs, (c) The making of solutions by the nurse, "The Future of the Schools of Nursing in the Light of the Grading Committee." 1.30 p. m., closing business session.

Rhode Island: The RHODE ISLAND STATE NURSES' ASSOCIATION held its annual meeting on January 30, in the Medical Library, Providence, with an attendance of more than 100. Col. H. Anthony Dyer spoke on Italy; Mary S. Gardner discussed the book, "Nurses, Patients and Pocketbooks;" Winifred L. Fitzpatrick spoke on insurance for nurses and the Relief Fund. The members adopted a resolution expressing their loss in the departure from their midst of Ellen L. Selby, a past president and a member of the Board of Nurse Examiners, who has recently given up the position of Superintendent of the Pawtucket Hospital which she had held for thirteen years. Officers elected are: First vice president, Grace Breadon; recording secretary, L. M. Belle Avery; assistant corresponding secretary, Mrs. Helen G. Batchelder; treasurer, Mrs. Christy R. Oliver; directors, Helen O. Potter, Elizabeth Sherman, Mrs. Hazel Davis.

District and Alumnae News

Arizona: Phoenix.—DISTRICT 1 entertained the members of the State Board of Examiners at luncheon on January 12. Mrs. Kathryn Hutchinson, President of the State Association, who is also a member of the Board, visited the two schools in the city and was present at the meeting of District 1.

Connecticut: New Haven.—At the annual meeting of the VISITING NURSE ASSOCIATION, held on January 28, the speakers were Mrs. C.-E. A. Winslow, Mary Grace Hills, and Marie L. Donohoe of the Boston Community Health Association.

District of Columbia: Washington.—On January 19, the DISTRICT LEAGUE OF NURSING EDUCATION gave a luncheon for Laura R. Logan of Chicago. On January 21, a meeting of the League was held in the Auditorium of the Headquarters of the National Red Cross, when Miss Logan spoke on "Organizing University Schools of Nursing." The meeting was well attended.

Georgia: Columbus.—The FIFTH DISTRICT held a regular meeting on February 1 in the Parish House of Trinity Episcopal Church. An interesting bulletin from State Headquarters was read, explaining the readjustment of the nursing profession through the entire state; this was heartily approved. The subject of the program was "Public Health." Hettie Weldon gave a very intellectual talk on "Qualifications of a Public Health Nurse."

Illinois: Chicago.—The annual meeting of the FIRST DISTRICT ASSOCIATION was held Tuesday afternoon and evening, February 12 at the Nurses' Headquarters, 116 S. Michigan Avenue. Dora Cornelisen spoke at both sessions, giving her very interesting story of the *Journal* and plea for greater support and coöperation. First District has a membership of 4,300 members, 1,985 of whom are private duty nurses and approximately 600 public health nurses. The Section meetings of these groups have been very interesting and in most instances well attended, particularly those of the Public Health group. The report of Registry shows that the registrar has had to discourage rather than encourage increased membership, as many more apply than there is work for. Hourly nursing has grown steadily, and is almost on a self-supporting basis. In July Miss Ahrens, Executive Secretary for the past five years, presented her resignation to take effect October 1. At a special meeting the Board of Directors decided that a committee be appointed to study First District activities and, on the basis of this study, to make recommendations to the Board. The Relief Fund shows contributions of $612 and the sum of $417 was contributed towards the nurses' cottage at Naperville. New officers elected are: President, Ella Best; vice president, May Kennedy; treasurer, Mrs. Katherine Williams; directors, Mabel Christie, Marion Kirkcaldy, Bertha Knapp, Sara B. Place, Margaret Saenger, Anna Willenborg, Grace Bradley, Lenore Tobin. The annual meeting of the ILLINOIS TRAINING SCHOOL ALUMNAE was held at First District Headquarters, January 9. Officers elected are: President, Bertha Harding; vice presidents, Selma Nelson, Louise Pequinot; recording secretary, Marcia

Blake; financial secretary, Gertrude Reid; directors, Minnie Ahrens, Charlotte Johnson, Nellie G. Miller, Mary Watson, Anna Bryce.

Indiana: Fort Wayne.—A very successful "Journal party" was held at the Lutheran Hospital on the evening of February 9. It is hoped to publish a description, later. **Hammond.**—The SECOND DISTRICT ASSOCIATION met at the St. Margaret Hospital, January 12. Marian L. Moore, South Bend, the new president, gave a splendid talk and asked the individual coöperation of each member to make the coming year one of activity and increased membership. It was stated that the annual convention of the State Nurses Association will be held at South Bend this coming fall, and the Second District will serve as hostess. The ST. MARGARET HOSPITAL ALUMNAE held their annual meeting on January 14 in the Nurses' Home. Angela R. Reinke, R.N., was reëlected as president; Elizabeth Jablonski, R.N., was chosen vice president; Ruby Rudolph, secretary, and Lena Spolnik, treasurer. A check for $10 was mailed to the treasurer of the Second District as their contribution to the Florence Nightingale Building Fund. The next meeting of the Second District will be held at the Methodist Hospital, Gary, in March. **Richmond.**—At a business meeting of the ALUMNAE ASSOCIATION OF REID MEMORIAL HOSPITAL, held January 16, tentative plans for future activities were discussed. Twenty-one were present.

Iowa: Des Moines.—The regular meeting of the SEVENTH DISTRICT was held on February 7, when Mrs. J. A. Blanchard, a parliamentarian, gave a very worth-while general talk on "Parliamentary Usage." Millie Jacobson, Superintendent of Nurses, Iowa Lutheran Hospital, gave a short talk on "Nursing Education."

Louisiana: New Orleans.—The annual meeting of the NEW ORLEANS DISTRICT NURSES' ASSOCIATION was held at the Club House, January 31. Isabelle McCaughn was elected president to succeed Barbara Frank, who had served for four years. Miss Frank has been untiring in her efforts in behalf of the Association. Under her administration the Association purchased the Club House. Two new alumnae associations were admitted to the District—The Southern Baptist Hospital and The Soniat Memorial-Mercy Hospital. A pair of silver candlesticks were presented to Miss Frank as a token of appreciation and esteem. Other officers elected were: Mrs. B. P. Avils and Juanita Bayhi, vice presidents; Alice Jordan, secretary; Marthe McKendrick, treasurer; Virginia Monroe, chairman of the Finance Committee; Mrs. C. D. Wilson, chairman of Credentials Committee; Sara Babb, chairman of Legislative Committee; Mrs. Lena Cross, chairman of Program Committee; C. A. Barney, chairman of Publication and Press Committee; and Mrs. Lydia Breaux, chairman of Nominations Committee. Three counselors elected: Daisy Rose, Mrs. I. V. Haley and Barbara Frank. The members adopted resolutions expressing their sense of loss in the death of Louise Agnes Daspit, "whose life has been an unbroken chain of valuable performances, and whose noble deeds of professional ethics and kindness all serve as a beacon light to posterity."

Massachusetts: Arlington.—The SYMMES ARLINGTON HOSPITAL TRAINING SCHOOL celebrated its tenth anniversary February 2. The Superintendent, Nora A. Brown, arranged a birthday cake with ten candles for each individual table, and a special luncheon was prepared for all the students in training. **Boston.**—The 57th semi-annual business meeting of the CHILDREN'S HOSPITAL NURSES' ALUMNAE ASSOCIATION was held, January 14, with seventeen members present. Officers for the year 1929 were elected: President, Stella Goostray; vice president, Dorothy Foster Stewart; secretary, Virginia J. W. Haw; treasurer, Gertrude E. Maloney; councilor, Virginia J. W. Haw; members of the Executive Council: Alice Jones Newhall, Katherine Hitchcock, Ida Buckley, Katherine Washburn. **Waverly.**—The MCLEAN HOSPITAL NURSES' ALUMNI ASSOCIATION held its mid-winter meeting on January 24. Helene G. Lee, Executive Secretary of the State Association, was the speaker.

Michigan: Albion.—SHELDON MEMORIAL HOSPITAL ALUMNAE elected for its officers: President, Lucretia Juckett; vice president, Laura Honeywell; secretary, Viola Cook; treasurer, Ruth Strain. Mrs. Mary E. McDonald, who has been superintendent of James W. Sheldon Memorial Hospital since 1924, has resigned. She will be succeeded by Winifred Seckinger of Jackson. **Battle Creek.**—The annual meeting of the BATTLE CREEK DISTRICT ASSOCIATION was held January 22 at the West Hall, Battle Creek Sanitarium. The following officers were chosen for the year: President, Ruth Tappan; vice president, Josephine Nichols; corresponding secretary, H. Lucretia Juckett; recording secretary, Clara Gasser; treasurer, Mrs. Addie Taylor; directors, Leone Sweet,

Sara Vail, Mrs. Mary Staines Foy, Mrs. Mary McDonald, Mrs. Elizabeth Nichols, Fantine Pemberton. The Battle Creek Sanitarium School of Nursing Alumnae has elected the following: President, Fern Sheik; vice president, Erma Scramlin; corresponding secretary, Jessie Midgely; recording secretary, Ellamae Palmer; treasurer, Mrs. Effie Tyrel; directors, Isabelle Collinson, Mrs. Mary Staines Foy, Ruth Tappan, Elva Osborn, Leone Sweet, Winifred Bowers. The officers of the NICHOLS MEMORIAL HOSPITAL ALUMNAE are: President, Marion McCauley; vice presidents, Mrs. Irma Platt Green, Elizabeth Swanson; secretary, Margaret Baker; treasurer, Mrs. Laura Clough. **Detroit.**—Mrs. Anne L. Hansen, President of the National Organization for Public Health Nursing, was the speaker at the February meeting of the DETROIT DISTRICT ASSOCIATION. The meeting was held in the Education Building of the Henry Ford Hospital School of Nursing and Hygiene. Mrs. Hansen chose as her subject "Appraising Our Services." The annual meeting of the Detroit Visiting Nurses' Association was held in the auditorium of the Tau Beta Community House on February 1. Mrs. Anne L. Hansen was the speaker, and discussed community problems in nursing.

Minnesota: A new district, the EIGHTH, was organized on December 14, with the following officers: President, Hulda Petry, Montevideo; vice presidents, Evelyn S. Malmstrom, Frances Holtan; secretary, Rebecca Peterson; Ortonville; treasurer, R. Esther Ericksen.

Missouri: St. Louis.—At the last meeting of the ST. LOUIS LEAGUE OF NURSING EDUCATION, the following officers were elected: Grace Grey, Jewish Hospital, vice president; Jessie V. Davis, St. Luke's Hospital, treasurer; Dorothy Rogers, Barnes Hospital, director.

New Jersey: Orange.—The annual meeting of the ALUMNAE ASSOCIATION OF THE ORANGE MEMORIAL HOSPITAL was held on January 16. The following officers were elected: President, Helen Stevens; secretary, Marion Frey; treasurer, Cora Baker; Director, Saidee MacFall. **Spring Lake.**—The annual meeting of DISTRICT 4 was held at the Ann May Memorial Hospital, January 28. About sixty members, students and guests were present. The following officers were elected for the year 1929: President, Sara Van Gelder, Perth Amboy; vice president, Marian Winters, New Brunswick; secretary, Minnie Ireland, Long Branch; treasurer, Mrs. Margaret Brown. Neptune; director, three years, Beatrice Colley; director, two years, Harriet Cook; director, one year, Mrs. Martha M. Scott. Professor Kull of Rutgers University was present, and gave a most interesting talk on "The Influence of History on Civilization." Arabella R. Creech, Executive Secretary of the State Association, gave some very useful information regarding the Bordeaux Memorial and the Relief Fund.

New York: Brooklyn.—*Nursing News*, the official organ of DISTRICT 14, was issued in January, a sixteen-page bulletin, of attractive appearance, full of interest to its clientele. **New York.**—SECTION ONE OF THE STATE LEAGUE is devoting its meetings to a consideration of the qualifications and preparation of head nurses. The very unusual attendance and the presence of a large number of young nurses is an index of the value of the programs which are arranged by a committee of which Mary M. Marvin is chairman. At the meeting on February 6, the topic was discussed from many angles, as follows: from the standpoint of the administrator, by June Ramsey of the Pasadena Hospital; from the standpoint of the supervisor, by Lelin Townsend of the Neurological Institute; from that of the instructor in nursing practice, by Miss Goodine of Mt. Sinai Hospital. Mary E. Robinson of the Long Island College Hospital summarized the interesting opinions of a class of Senior students. The topic "Preparation of the Head Nurse" was presented by Blanche Edwards of Bellevue, where a highly organized piece of staff education has been under way for about two years. The program closed with a discussion of some of the field work included in the Course for Head Nurses now given at Teachers College. The importance of the head nurse, and the urgent need of preparation were sharply defined. The hopeful note was sounded by those who have plans already under way for helping the head nurse to find ways and means for teaching in the wards and, in some instances, for giving them graduate assistants. **Syracuse.**—The tenth annual meeting of DISTRICT 4 was held at Syracuse University Hospital, January 10. The following officers were elected: President, Ida M. Finch; vice presidents, Eva Gilbert, Ruth Murdock; secretary, Frances E. King; treasurer, Louise Sherwood; directors, Lena Breen, Viola Wilcoxen. The members are happy to report that District 4 ranks highest in the state, per capita, for Nurses' Relief Fund. **Saranac Lake.**—DISTRICT 8 held its annual meeting on January 8 at the Trudeau Nurses' Home. Officers elected are: President, Alice M. de Ward;

vice presidents, Madeline Smith, Ophelia Sawtell; secretary, Mary Olive Smith; treasurer, Blanche F. Mann; directors, Margaret Bryce Mundie, M. Camilla Hayes. A report of the Free Bed Fund was made by Emily Denton, Superintendent of the Hospital. Plans for the coming year were discussed.

Ohio: Cincinnati.—The regular monthly meeting of DISTRICT 8 was held at Deaconess Hospital. The program was under the auspices of the Public Health Section. Dr. W. E. Hickerson of the Cincinnati Department of Health gave an interesting talk on "Tuberculosis." The card party and sale, given by the District Emergency Relief Fund Committee, netted approximately $1,000. On Sunday, February 3, the new Nurses' Home of Christ Hospital was dedicated. The reading room of the new home is a memorial to Maude J. Silver, former Superintendent of the School of Nursing. There are accommodations for 250 nurses. **Columbus.**—DISTRICT 12 held its meeting in the Mount Carmel Nurses' Home, February 6. Caroline V. McKee, Chief Examining Nurse, gave an illustrated lecture on "Graphic Representations on Conditions Pertaining to Schools of Nursing in Ohio." **Youngstown.**—DISTRICT 3, in its annual report, gives its membership as 363. The District has joined the Youngstown Federation of Women's Clubs. It has supplied the South Side Branch of the Public Library with a subscription to the *American Journal of Nursing*. A contribution of $100 was sent to the Grading Committee. One hundred League calendars were sold.

Oregon: Portland.—At a meeting of DISTRICT 1, held on January 30, the League of Nursing Education conducted a discussion of "Nurses, Patients and Pocketbooks," which aroused great interest. Representatives were present from practically all the nursing schools and from every type of nursing. The program was:

1. "Nurses, Patients and Pocketbooks," Grace Phelps. A report of the study being made by the Committee on Grading of Schools of Nursing.

2. "The Hospital," Emma E. Jones. The relation of the hospital and the school of nursing. The hospitals' responsibility to the schools. The schools' responsibility to the hospitals. Budgets for schools of nursing.

3. "The School of Nursing," Cecil L. Schreyer. Kinds of schools now in operation in the United States. Oregon schools.

4. "The Student Nurse," Jane V. Doyle. Preparation to meet present day demands of the graduate.

5. "The Graduate," Glendora Blakely. Specialties available for the graduate. Are the needs for these special jobs being met?

6. "The Registry," Frances Platts. Types of registries in operation in the country. The value of the Official Registry. Report of District 1, Registry: (a) Average time the private duty nurse is employed during year. (b) Average income on basis of time registered on call. (c) Qualities most frequently mentioned and requested in calls for a nurse. (d) Most frequent complaints from doctors. (e) Most frequent complaints from patients. (f) Most frequent complaints from nurses to the registry. (g) The registry's complaints against nurses.

7. "The Patient," Emily Loveridge. The patient as the unit for service. The patient's problems. The nurse's problems. The doctor's problems. The hospital's problems.

Pennsylvania: Altoona.—ALTOONA HOSPITAL ALUMNAE ASSOCIATION met January 8 for the annual meeting. The following officers were elected for the ensuing year: President, Julia E. Galbraith; vice president, Pearl Dibert, Elsa Paul; secretary, Helen Balt; corresponding secretary, Arvilla Knisley; treasurer, Christine Martin. **Lancaster.**—A banquet for all city and county graduate nurses was held, January 22, under the auspices of the ALUMNAE ASSOCIATIONS OF LANCASTER HOSPITAL AND ST. JOSEPH'S HOSPITAL. Margaret Dunlop, Superintendent of Nurses of the Pennsylvania Hospital, Philadelphia, spoke on high standards for schools of nursing. Ella Hasenjaeger, Superintendent of the Lancaster Hospital, urged the establishment of scholarships by the alumnae for the students. Brief talks were given by Alice Swank of St. Joseph's Hospital, Mary Eckman and Anna Houck, the alumnae presidents, and by Mary Prosser of Columbia Hospital. The banquet closed with a candle ceremony, during which the entire group repeated the Nightingale Pledge. More than 125 were in attendance. **Meadville.**—Lydia S. Whiton has resigned as Superintendent of the Meadville Hospital, after a service of eighteen years. Many regrets were expressed at her leaving by directors of the hospital and by her own colleagues. Dinners and luncheons were given in her honor, and those who had been trained by her tried to express what her teaching and example had meant to them. Miss Whiton is in frail health; she has gone to her home in Hingham, Mass. She is succeeded by

Clara M. Widdifield. **Philadelphia.**—The ALUMNAE OF HAHNEMANN HOSPITAL met on January 8. Election of officers for the year followed: President, Mrs. B. Ashworth Fisher; vice president, Annabel Smith; secretary, Alice O. Walter; treasurer, J. Emilie Kempe. Twenty-seven new members were received during the past year. All members feel a great interest in the new Greater Hahnemann Hospital, which was opened on January 3. A general reunion of all graduates of the school will be held in May. Those who can attend are asked to notify the Secretary (Alice O. Walter, 5222 Webster St., Philadelphia) by April, as all addresses are not available. The Alumnae meeting of the PROTESTANT EPISCOPAL HOSPITAL was held January 7. It was the annual meeting with the election of officers: President, Anne Behman; vice presidents, Edith Killian, Mrs. Nellie Pennock; secretary and treasurer, Mrs. Ethel K. Griffith. **Pittsburgh.**—The MONTEFIORE HOSPITAL NURSES' ALUMNAE ASSOCIATION will hold an open meeting, on March 5, at the nurses' residence. Dr. Luba Robin Goldsmith will be the speaker of the evening. A very interesting program has been arranged. The Alumnae regrets exceedingly to lose from its school, Marguerite Hunt, who left Pittsburgh, February 15, to assume her duties as principal of the School of Nursing at the New Rochelle Hospital, New Rochelle, N. Y. The Alumnae extends its best wishes to Miss Hunt in her new position. **Wilkes Barre.**—The annual meeting of DISTRICT 3 was held at St. Stephen's Parish House, January 16. The regular business of the Association was transacted and the following officers were elected: President, Sarah H. Smith, Scranton; vice presidents, Lydia Barber, Pittston, Emma Ballamy, Wilkes Barre; secretary, Sister Avellino, Scranton; treasurer, Jennie M. Huff, Pittston; directors, Nellie Loftus, Jeannette Edwards. The meeting was followed by a dinner at which Esther Tinsley, President of the State Association, was the guest of honor.

Rhode Island: Newport.—Minnie Goodnow has been appointed Superintendent of Nurses at the Newport Hospital. **Providence.**—On January 17, nurses and representatives of nursing associations throughout the state gave a dinner in honor of Ellen M. Selby, who had recently severed her connection with the Memorial Hospital, Pawtucket, where for thirteen years she has served as Superintendent of the Hospital and the School. Grace Breadon, President of the Rhode Island League of Nursing Education, presided at the dinner. Lucy C. Ayres reviewed the contribution made by Miss Selby to the cause of nursing and nursing education in Rhode Island. Mary S. Gardner paid tribute to the guest of honor, commending her for her idealism and high standards. Miss Gardner, in behalf of the nurses present, presented Miss Selby with a string of crystal beads.

Texas: Abilene.—DISTRICT 15, at its annual meeting, elected as president, Maude Whitley Cooze, Superintendent of the Stamford Sanitarium School for Nurses. A special guest at the meeting was Mrs. Myra Cloudman of St. Louis, representing the American Red Cross.

Virginia: Richmond.—The formal opening of Cabaniss Hall of the Department of Nursing, Medical College of Virginia, was observed on February 15. Dr. Joseph L. Miller spoke on "Physicians of the Old South"; Dr. Charles R. Robbins spoke on "Beginnings in Nursing Education under Sadie Heath Cabaniss."

Washington: Seattle.—Evelyn H. Hall retired as Superintendent of the Seattle General Hospital, on January 9, after an untiring service of twenty-five years. Miss Hall has not only given most efficient service to her hospital, but she has been a member of the State Examining Board for many years. Miss Hall has had an extraordinary influence on all with whom she worked, not only her colleagues and students, but members of the community, as well, so that she has been a civic force. She is honored by being named as superintendent emeritus of both the hospital and the school of nursing.

Wisconsin: Green Bay.—DISTRICT 9 held its regular meeting, on January 16, in the auditorium of the new Nurses' Home at St. Mary's Hospital. It was voted to organize a Private Duty Nurses' Section to afford a common meeting ground for the private duty nurses where their problems can be discussed. Jeanette M. Hays, Director of Headquarters of Districts 4 and 5, Milwaukee, gave a very interesting talk on the present system of organization, tracing the affiliation from the American Nurses' Association down through the alumnae associations and bringing out the value to the individual nurse of such affiliation. After the meeting the nurses were invited to inspect the new nurses' home which is a splendid building.

Deaths

Esther Ewer (class of 1927, Toledo Hospital, Toledo, Ohio), of peritonitis. Miss Ewer had an excellent record as a student, and she was successful in the field of private duty. Burial was at Macy, Ind.

Jean B. Giffen (class of 1902, Norwich Hospital, Norwich, England), on January 21, of influenza and pneumonia, at the New Rochelle Hospital, New Rochelle, N. Y. Services were held in Lockport, N. Y., where, for five years, Miss Giffen had been Superintendent of the Lockport City Hospital. Miss Giffen's illness occurred while she was on a short visit to New York. Miss Giffen was a graduate of the Royal Edinburgh Sick Children's Hospital. She held the position of Head Nurse in the Operating Room at Swansea General Hospital, and was later Superintendent of the Private Hospital at Swansea. For a number of years she was Assistant Superintendent at the Pendlebury Children's Hospital, Manchester. On coming to Canada, she was first Superintendent of the Royal Edward Institute, Montreal, later on the staff of the Montreal General Hospital and Superintendent of the Children's Memorial Hospital, Montreal. From there she went to New York City for graduate work at Columbia, and was in charge of the Brooklyn Children's Hospital. She then went to Lockport. During the War she enlisted and served in France at Boulogne and in London.

The average man or woman who came in contact with her did not at first realize the abundant sacrifice which Miss Giffen continually made of her own time and strength for the welfare, comfort and progress of hospital work. It is only possible to discover this from the abundant tributes of others who knew her intimately, for she never spoke of herself. Those close to Miss Giffen at the time of her death observed the immediate response which those professionally in attendance upon her made to her superlative personality, as they sought to do everything possible for her comfort and recovery. But she died, as she lived, quietly avoiding everything that she thought might cause effort on the part of others.

Professional to her finger-tips, she was also completely human in her sympathy and thoughtfulness. No smallest need was too humble for her to see, and no greatest emergency ever threw her off her poise. She carried on and helped forward the ideals which make the nursing profession an honor and a glory. As a teacher of students she was at her best, and many nurses in all parts of the world will long cherish the memory of her brave influence for every high standard of the profession.

Louise Golder, at the Bethesda Hospital, Cincinnati, Ohio, on January 9, of influenza and pneumonia. Miss Golder was born in Germany, but came to America in 1877, and was the founder of Bethesda Hospital; she was also its Superintendent until 1898. She retained the title of Superintendent of Deaconess Motherhouse of this institution until her death. Miss Golder was widely known on two continents as a Deaconess leader.

Bessie Gorman (class of 1905, St. Luke's Hospital, Utica, N. Y.), on January 9, at Sea View Hospital, Staten Island, N. Y., following a short illness with pneumonia. Miss Gorman had not only been loyal and faithful in the performance of her duties, but untiring in her desire to serve others; she was greatly beloved by all with whom she came in contact.

Lillian Hammel (class of 1916, St. John's General Hospital, Pittsburgh, Pa.), of pneumonia. Miss Hammel was a private duty nurse, a woman of sterling character, ever faithful to her profession. She will be greatly missed by all her friends.

Gertrude Harris (class of 1924, Braddock General Hospital, Braddock, Pa.), on December 21, 1928, at the Braddock General Hospital, after an illness of four days. Miss Harris had a pleasing personality, and was engaged in private duty nursing to the time of her death. She is missed by her friends and the members of the Alumnae Association, of which she was an active member.

Gunhild G. Johnson (class of 1914, Augustana Hospital, Chicago, Ill.), on January 18, after three weeks' illness with pneumonia. Burial was at Iron Mountain, Mich. Miss Johnson's death occurred at the time that she was serving on the staff of the Visiting Nurse Association of Brooklyn, N. Y. She apparently chose School Nursing as her major interest, and served in that capacity in the City Health Department of Chicago and the Boards of Education of Jacksonville and Decatur, Ill. Two of the outstanding events of her nursing experience were her year with the U. S. Army Nurse Corps, Overseas Army Base 11, in 1918–1919, and the summer of 1925 spent in Labrador with the Grenfell Association. Interspersed with this rich and varied experience were periods of intensive study in the summer schools of the Universities of California and Michigan and the Cleveland School of Education. Miss Johnson

had the qualities of mind and heart that make a woman and a nurse steadily attractive—a woman of broad sympathy and never harsh judgment. She had an abundance of human feeling that kept her sympathetic towards nurses and patients and made her generous to them. Her sudden passing has brought a sadness of heart to her coworkers and a host of friends in many parts of the country.

Isabel Lauver (class of 1883, Illinois Training School, Chicago), on December 4, at Elgin, Ill. Miss Lauver was one of the earliest graduates of her school, and she was the first night nurse on duty in Cook County Hospital. She did private duty nursing for some years and then held several institutional positions. She was a woman of fine ideals and upright character.

Mollie McIntire (graduate of the Joseph Price Memorial Hospital, Philadelphia, Pa.), at her home in Baltimore, Md., of pneumonia, on January 22. For a number of years Miss McIntire was Chief Nurse of the Philadelphia Dispensary. She is truly mourned by a host of friends.

Estella McNamara (class of 1907, Finlay Hospital, Dubuque, Iowa), on January 28, at Junction City, Kans., after an illness of five days, due to gastric hemorrhage. Miss McNamara will be remembered by all who came in contact with her as a person of fine character who practised the high ideals of her profession. She had taken a course in x-ray technic at St. Luke's, Chicago, and in anaesthesia at Grace Hospital, Detroit, Mich. She held various positions during her nursing life: at Finlay Hospital, Dubuque; at Jennie Edmunson Memorial Hospital, Council Bluffs, Ia.; Paxton Memorial, Omaha, Neb., and at the time of her untimely death she was in charge of the hospital at Junction City, Kans.

Effie Lantz Power (class of 1927, Graham Protestant Hospital, Keokuk, Iowa), on December 9, in Baltimore, Md., Mrs. Power was instantly killed by a street car, in attempting to save a child. She had recently finished a postgraduate course in surgery at Johns Hopkins, and was employed at the Dr. Howard A. Kelley Hospital at the time of death. She will be greatly missed by her friends, and the nursing profession has lost a most loyal and efficient member.

Sister Mary Elzear (graduate of St. Mary's Hospital, Rochester, Minn.), on November 24, at St. Mary's Hospital, after a lingering illness. Sister Elzear was for ten years a head nurse or teaching supervisor; she had the spirit of a true teacher and made a lasting contribution to her school. Self-sacrificing and helpful, her life will be a lasting inspiration to those who knew her.

Sister Mary Emma (graduated, as Miss Fillion, class of 1914, St. Vincent's Hospital, New York), on January 10. Miss Fillion did private duty and industrial nursing until 1920, when she became a Sister of Charity of Mount St. Vincent and, as Sister Mary Emma, devoted herself whole-heartedly to the work of St. Vincent's Hospital. She will be much missed by the Sisters and nurses of the hospital.

Caroline H. Soellner (graduate of Lakeside Hospital, Chicago), recently, of pneumonia, following influenza. Miss Soellner was Superintendent of Roseland Community Hospital, Chicago, at the time of her death. She had been ill with a severe cold for a month previous to her death, but remained at her post until three days preceding it. The prevalent influenza epidemic had taxed the capacity of her hospital to the utmost, and the disease had also attacked a number of the nursing staff. Miss Soellner, against the advice of the hospital doctors, not only remained on active duty, but assumed extra burdens in her concern that her nurses and patients receive the best possible care. Beloved by all who knew her, Miss Soellner has made some useful contributions to the nursing world of which she was a member for twenty years, and to which she gave so generously of herself and of her talents that she might leave it better than she found it. She was for eight years Superintendent of Blessing Hospital, Quincy, Ill. Returning to Chicago, she was successively Superintendent of Nurses at Washington Park and Lakeside Hospitals, Instructress of Nurses at Michael Reese Hospital, and Superintendent of Nurses at Roseland Community Hospital. In the nurses whom she trained so capably in these five hospitals, her work continues.

Helen E. Wood (class of 1913, Deaconess Hospital, Omaha, Neb.), on January 5, in Sparta, Wis., after a long illness. Miss Wood had never been strong, but in spite of her frailty she held positions at Asbury Hospital, Minneapolis, as night supervisor, at the Deaconess Hospital, Brooklings, S.D., as Superintendent, and at Danville, Ill. Her last work was done in Chicago. She was always devoted to her work and helpful to others.

About Books

A Study of Some of The Problems Arising in the Admission of Students as Candidates for Professional Degrees in Education. By Clarence Linton, Ph.D. 161 pages. Bureau of Publications, Teachers College, Columbia University, New York City. 1927. Price $1.50.

THE hunger of nurses for more knowledge is one of the most encouraging things in the nursing profession. It drives them to take courses, or to study many subjects, often those which will help them in their work, but not infrequently something to increase their appreciation and enjoyment of the treasures of art, music or literature. Almost invariably this leads to the realization of the value of a degree, and to a desire to earn one. Then it becomes necessary to assemble records of past education, and have them evaluated in terms of academic credit. Usually these will include the records of a course in a School of Nursing, and one naturally wishes them given as much credit as possible. For many nurses the result is disappointing. The records of Schools of Nursing are often incomplete, and even highly desirable courses may not fall into regular classifications, so that, with every desire to be just and generous, the evaluation is beset with difficulties.

Dr. Linton's book is a study of just such problems, although dealing primarily with the problems of teachers, not nurses. It makes interesting reading for, in many places, "nurse" could be substituted for "teacher" with equal truth. There is constant evidence that we are, as a profession, travelling the same road as the teachers, although we lag far behind them in progress.

One reads:

> There has been a rather steady trend upward in admission requirements from 1839 to 1926, and this raising of admission requirements has been paralleled by the levels of curricula offered in teacher-training institutions.

The organization of various accrediting agencies for preparatory schools and colleges is outlined, and their purposes and accomplishments described. The knowledge of how small a beginning has been made in standardizing the preparation of nurses makes one read, with a feeling akin to envy, the advances made in that regard in the education of teachers, doctors, lawyers, dentists, etc.

The purpose of this book is outlined under four headings, the fourth being "to make recommendations relative to the procedure of officials responsible for the admission of students to professional work in education." This is the one that is of special interest to nurses.

Chapter II deals with "The admission of students without advanced standing as candidates for the Bachelor's degree in education." All those interested in the development of nursing courses that lead to a degree will find much of value in this chapter.

Chapter III deals with "The admission of students *with* advanced

standing as candidates for the Bachelor's degree in education." This is where the shoe pinches us. Careful study of this chapter will make clear why it is so difficult for nurses to get what they consider full credit for work done in a school of nursing, particularly if it is based on less than full high school.

Chapter IV is of interest to those who want to increase their knowledge regarding "The admission of students as candidates for the Master's degree in education."

Chapters V, VI, VII, are of more general interest, containing a "general summary of findings and conclusions" and suggesting standards to be adopted by our various colleges, so that admitting officers in all colleges will be guided by the same rules and may apply the same standards.

This book will be a valuable addition to any training school library. Careful study of it will help many students to see the discrepancies and weak places in their own preparation, so that they may remedy these without having them pointed out by another.

CAROLYN E. GRAY, M.A., R.N.
New York.

FOOD, NUTRITION AND HEALTH. By E. V. McCollum, Ph.D., Sc.D., and Nina Simmonds, Sc.D. (Hygiene). Second edition. 148 pages. Published by the authors, Baltimore, Maryland. 1929. Price, $1.60.

DR. McCOLLUM and Miss Simmonds have again produced a masterpiece in their revised edition of "Food, Nutrition and Health."

The book contains the latest facts concerning vitamins. From these scientific facts it proceeds along the social line of Life History in Relation to Diets and Dietary Habits of Man. These chapters are no less scientific, however, because of their social nature.

The two chapters on How to Reduce the Weight and How to Increase the Weight are important. The chapter on Hygiene of the Digestive Tract could profitably be read and re-read.

The book is valuable not only to the graduate nurse and her patient, but it should be in every library of a Training School for Nurses to be used in their seminar work.

BERTHA M. WOOD.
East Northfield, Mass.

BOOKS RECEIVED

THE OPERATING ROOM. Instructions for Nurses and Assistants at St. Mary's Hospital, Rochester, Minn. Second edition, revised. 235 pages. Illustrated. W. B. Saunders Company, Philadelphia. 1928. Price, $2.25.

In this new edition, an outline for classroom work in operating-room technic appears before the description of actual preparation for specific operations. The description of the duties of each nurse in the operating room is more detailed than in the previous edition, and the pictures of the technic of various operations will increase the nurse's understanding of her duties.

AFTER THE RAIN: Cleanliness Customs of Children in Many Lands. By Grace T. Hallock. 112 pages. Illustrated. Published by the School Department of Cleanliness Institute, New York. Second edition. 1929. Samples sent free to schools.

THE NURSING MIRROR DIARY FOR 1929. A Pocket Reference Guide for Nurses and Midwives. Twenty-second year. Enlarged and revised. 390 pages. Faber and Gwyer, Ltd. Russell Square, London, Eng. Price, 1/6.

PROCEEDINGS OF THE WOMEN'S CONFERENCE, held under the auspices of the Pan-Pacific Union in Honolulu, in August, 1928. Obtainable from the Pan-Pacific Union, Honolulu. Price $1.25.

This book gathers together material from Oriental countries which has never before been available in English. The Conference convened in five interest sections, in Education, Government, Health, Industry and Social Service.

Books You Will Enjoy

ISABEL ELY LORD

ONE of the most important books of the year is *Whither Mankind?* Edited by Charles Beard, it consists of a series of monographs on the various aspects of modern civilization and the problems of the "machine age." Although each was written separately, they fit together in an extraordinary way, and are on the whole optimistic. The one on "Health" by Dr. C.-E. A. Winslow is one no nurse can afford to miss. And she will want to read the rest of the volume, too, to add one more to those who are thinking out solutions for the danger of materialism that is confronting us (Longmans, $3).

Hunger Fighters is Paul de Kruif's sequel to *Microbe Hunters*, and deals with the search for evils that afflict human beings as well as those that reach men through the foods they grow. The stories are told picturesquely and even slangily, but they are really-truly stories, and worth reading for the facts that they contain as well as for the human interest of the men who did the work. The book appeals to every kind of reader who cares for anything but fiction (Harcourt, $3).

As an appendix to *Elizabeth and Essex* you will like Milton Waldman's *Sir Walter Raleigh* (Harper, $4). It has not the brilliancy of Mr. Strachey, but it is mighty interesting reading, nevertheless.

A biography full of valuable psychological material is Elith Reumer's *Hans Andersen the Man* (Dutton, $3.50). The most famous of all tellers of fairy tales had a curious life and a curious temperament. Everyone who loves Andersen will enjoy the book.

Never was there a more delightful animal story than Felix Salten's *Bambi* (Simon and Schuster, $2.50). Bambi is a deer, and we follow him from the day of his birth until the day when he seeks the hidden places to live alone and safe from Him—the terrible creature who comes with an "extra arm" to the forest and deals death to those there. Mr. Salten is a poet, and the picture of the woods and its people is an unforgettable one.

One of the problems of modern days is certainly that of the married life of two who have "careers" to consider. A. Hamilton Gibbs' *Harness* is the story of two such, delightful people who love each other truly, who come at the last out of most of their troubles. There is nothing harrowing in the book (Little, Brown, $2.50).

The *Galatea* of Margaret Rivers Larminie (Houghton, $2.50) is a pleasant book for reading aloud. How the woman who had led an isolated and circumscribed life up to maturity reacted to unexpected wealth and its opportunities, is interwoven with the tragic story of two friends who come into her life with her money.

For those who like the historical novel, the *Empress of Hearts*, by E. Barrington, is a good choice (Dodd, $2.50). It is the story of Marie Antoinette and the famous or infamous diamond necklace.

Our Contributors

"Nursing Medical Patients" is an extraordinarily valuable article, as it should interest private duty nurses as well as teachers and students. **Florence K. Wilson, R.N., A.B.,** is a graduate of the University of Michigan and of the New York City Hospital Training School for Nurses. She is Instructor and Supervisor in Medical Nursing in the Western Reserve School of Nursing.

Florence J. Potts, R.N., an expert in the fields of pediatrics and orthopedics, is Director of Nursing, Shriners' Hospitals for Crippled Children.

The data on the British College of Nurses was secured through the good offices of the secretary, **Grace Reynolds Hale.**

A. E. Bennett, M.D., is a psychiatrist and is Associate Professor of Medicine, University of Nebraska Medical School.

Margaret Wellman Huggins, R.N., is a graduate of the University of Michigan Hospital School of Nursing and was successively Head Nurse and Instructing Supervisor in the Operating Rooms of her Alma Mater.

Mrs. Anne L. Hansen, R.N., is President of the National Organization for Public Health Nursing and Director of the Buffalo Public Health Nursing Association.

In striking fashion, **Dr. May Ayres Burgess** has used some of the data collected for the Committee on Grading Nursing Schools to show the dreadful unevenness of distribution of nursing service.

Carrie M. Hall, R.N., Chairman of the Committee to Study the Harmon Association Annuity Plan, announces the approval of the Boards of the national organizations of the Plan presented in this issue. Miss Hall is now chairman of a committee which will consolidate the activities of this committee, of the Insurance Committee and the Relief Fund Committee.

It was through the influence of **Gladys Smits, R.N.,** the energetic superintendent of the Lincoln General Hospital and School of Nursing, that the beautiful Nurses' Residence was secured. Mrs. Smits designed the study tables and contributed many other original ideas to the home.

Leila I. Given, R.N., B.S., is a graduate of the Cottage Hospital School of Nursing, Creston, Iowa, and of Teachers College, New York. She is Instructor in Bacteriology, Western Reserve School of Nursing, Cleveland, Ohio.

The article on "Nursing in French Canada" was prepared for the "*I. C. N.*" by **Edith B. Hurley, B.A., R.N.,** Professor of Public Health Nursing, Université de Montreal, in collaboration with **Rev. Sister Augustine, F.C.S.P.,** Directress of Nurses, St. Jean-de-Dieu Hospital and President of the French section of Nursing Education of the Association of Registered Nurses of the Province of Quebec. **Mme. Rachel Bourque, R.N.,** first assistant, School of Public Health Nursing, Université de Montreal, also collaborated in its preparation.

"Spiritual Independence" by **Dr. Thomas Hayes Proctor,** Professor of Philosophy at Wellesley College, led us to ask **Brooke Peters Church** for "Hidden Sources," which will be followed in April by an intriguing article on Leonardo, the Great Amateur. Mrs. Church should be able to point out the way for busy women to find pleasure in the Fine Arts, since her own experience has included a degree from Bryn Mawr and unusual cultural contacts in two continents.

M. Zur-Linden, Chief Pharmacist, U. S. N., at the U. S. Naval Hospital, Portsmouth, Va., is an instructor in the Pharmacist's Mates' School which trains what, in civil life, would be called "male nurses" for the Navy.

Bertha M. Wood again contributes some very practical suggestions.

Edith Foster Flint, Ph.B., is Professor of English and Chairman of the Women's University Council, University of Chicago.

Gertrude S. Banfield, B.A., R.N., is Supervisor of Max Epstein Clinic and Instructor of Clinical Nursing, University Clinics, the University of Chicago.

M. Cordelia Cowan, R.N., B.S., is the Educational Director of the Postgraduate School for Nurses of the Woman's Hospital, New York City.

Official Directory

International Council of Nurses.—Sec., Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

The American Journal of Nursing Company.—Offices, 370 Seventh Ave., New York. —Pres., Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee, Wis. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Mary M. Riddle, care American Journal of Nursing, New York, N. Y. Elsie M. Lawler, Baltimore; Sally Johnson, Boston; Mrs. Elsbeth Vaughan, St. Louis; Elizabeth G. Fox, Washington, D. C.

Committee on the Grading of Nursing Schools.—Director, May Ayres Burgess, Ph.D., 370 Seventh Ave., New York.

The American Nurses' Association.—Headquarters, 370 Seventh Ave., New York. Pres., S. Lillian Clayton, Philadelphia General Hospital, Philadelphia, Pa. Sec., Susan C. Francis, Children's Hospital, Philadelphia, Pa. Treas., Jessie E. Catton, New England Hospital for Women and Children, Dimock St., Boston 19, Mass. Headquarters Dir., Janet M. Geister, 370 Seventh Ave., New York. Sections: **Private Duty,** Chairman, Anna E. Gladwin, 268 E. Voris St., Akron, O. **Mental Hygiene,** Chairman, Effie J. Taylor, New Haven Hospital, New Haven, Conn. **Legislation,** Chairman, Josephine E. Thurlow, Cambridge Hospital, Cambridge, Mass. **Government Nursing Service,** Chairman, Elinor D. Gregg, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C. **Relief Fund Committee,** Chairman, Carrie M. Hall, Peter Bent Brigham Hospital, Boston. **Revision Committee,** Chairman, Marie Louis, Muhlenberg Hospital, Plainfield, N. J.

The National League of Nursing Education.—Headquarters, 370 Seventh Ave., New York. Pres., Elizabeth C. Burgess, Teachers College, New York. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Marian Rottman, Bellevue Hospital, New York. Ex. Sec., Nina D. Gage, 370 Seventh Ave., New York.

The National Organization for Public Health Nursing.—Pres., Mrs. Anne L. Hansen 181 Franklin St., Buffalo, N. Y. Director, Katherine Tucker, 370 Seventh Ave., New York.

Isabel Hampton Robb Memorial Fund Committee.—Chairman, Elsie M. Lawler, Johns Hopkins Hospital, Baltimore, Md. Sec., Katharine DeWitt, 370 Seventh Ave., New York.

New England Division, American Nurses' Association.—Pres., Sally Johnson, Massachusetts General Hospital, Boston, Mass. Sec., Mary Alice McMahon, Boston State Hospital, Boston 24, Mass.

Middle Atlantic Division.—Pres., Jessie Turnbull, Elizabeth Steele Magee Hospital, Pittsburgh, Pa. Sec., Gertrude Bowling, Visiting Nurse Association, Washington, D. C.

Mid-West Division.—Pres., Mabel Dunlap, Moline, Ill. Sec., Mrs. Alma H. Scott, 610 Traction Terminal Bldg., Indianapolis, Ind.

Northwestern Division.—Pres., E. Augusta Ariss, Deaconess Hospital, Great Falls, Mont. Sec., Floss Kerlee, State Hospital, Warm Springs, Mont.

Southern Division.—Pres., Jane Van De Vrede, 105 Forrest Ave., N. E., Atlanta, Ga. Sec., Bernardine Bryant, Selma, Ala.

Nursing Service, American Red Cross.—Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

U. S. Public Health Service Nurse Corps.—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau.—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau.—Supervisor of Nurses, Elinor D. Gregg, Office of the Medical Director, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C.

Department of Nursing Education, Teachers College, New York.—Director, Isabel M. Stewart, Teachers College, Columbia University.

State Associations of Nurses

Alabama.—Pres., Annie M. Beddow, Norwood Hospital, Birmingham. Sec., Linna H. Denny, 1320 N. 25th St., Birmingham. Pres. examining board, Helen MacLean, Norwood Hospital, Birmingham. Sec., Linna H. Denny, 1320 N. 25th St., Birmingham.

Arizona.—Pres., Mrs. Kathryn G. Hutchinson, Tombstone. Sec., Mrs. Mildred P. Fulkerson, 735 E. Moreland St., Phoenix. Pres. examining board, Helen V. Eagen, 618 N. 4th St., Phoenix. Sec.-treas., Catherine O. Beagin, Clifton.

Arkansas.—Pres., Ruth Riley, City Hosp., Fayetteville. Sec., Blanche Tomaszewska, 1004 W. 24th St., Pine Bluff. Pres. examining board, Walter G. Eberle, M.D., First National Bank Bldg., Fort Smith. Sec.-treas., Ruth Riley, Fayetteville.

California.—Pres., Anne A. Williamson, 2028 Primrose Ave., S. Pasadena. Sec., Ruth Wheelock, Community Hospital, Riverside. Director of headquarters, Anna C. Jammé, Room 502, 609 Sutter St., San Francisco. State League Pres., Mary M. Pickering, University of California, Berkeley. Sec., Helen F. Hansen, State Building, San Francisco. Acting Director, Bureau of Registration of Nurses, Sarah G. White, P. O. Box 1159, Sacramento.

Colorado.—Pres., Ann Dickie Boyd, 414 14th St., Denver. Sec., Irene Murchison, State House, Denver. State League Pres., Mrs. Dorothy Conrad, 800 Central Savings Bank Bldg., Denver. Sec., Ruth Colestock, Colorado General Hospital, Denver. Pres. examining board, Eleanor Lafferty, Minnequa Hospital, Pueblo. Sec., Irene Murchison, State House, Denver.

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New Orleans. Sec.-treas., Julie C. Tebo, 1005 Pere Marquette Bldg., New Orleans.

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North Dakota.—Pres., Esther Teichmann, 417 6th St., Bismarck. Cor. Sec., Mathilda Paul, Trinity Hospital, Minot. Pres. examining board, Josephine Stennes, Rugby. Sec., Mildred Clark, General Hospital, Devils Lake.

Ohio.—Pres., Clara F. Brouse, 94 Charlotte

St., Akron. Gen. Sec. and State Headquarters, Mrs. E. P. August, 85 E. Gay St., Columbus. Chief Examiner, Caroline V. McKee 85 E. Gay St., Columbus. Sec., Dr. J. M. Platter, 85 E. Gay St., Columbus.

Oklahoma.—Pres., Mrs. Grace Irwin, Clinton. Sec., Marjorie W. Morrison, 1120 N. Hudson St., Oklahoma City. State League Pres., Mabel Smith, University Hosp., Oklahoma City. Sec., Mary E. DeLaskey, 526 State Capitol, Oklahoma City. Pres. examining board, Jessie A. Biddle, Central State Hospital, Norman. Sec., Mrs. Candice Montford Lee, Route 4, Oklahoma City.

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